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GOVERNMENT HEALTH CARE CONTRACT INCENTIVES: MAKING MANAGED HEALTH CARE WORK IN FEDERAL GOVERNMENT PROCUREMENTS

A Thesis Presented to The Judge Advocate General's School
United States Army in partial satisfaction of the requirements
for the Degree of Master of Laws (LL.M.) in Military Law

The opinions and conclusions expressed herein are those of the author and do not necessarily represent the views of either The Judge Advocate General's School, the United States Army, the Department of Defense, or any other governmental agency.

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**47TH JUDGE ADVOCATE OFFICER GRADUATE COURSE
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Government Health Care Contract Incentives: Making Managed Health Care Work In Federal Government Procurements

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ABSTRACT: Contracting for managed health care systems is a complex undertaking. The current TRICARE contracts captured all the important parts of the system and ensured detailed compliance with the many system requirements. However, the TRICARE contracts do not allow for system changes and innovation because the specific contract requirements make change almost impossible. A compelling alternative to DoD's current, limited strategy of using traditional contract structure and type exists. Performance-based contracting with incentives is the best alternative. No legal or regulatory requirements prevent shifting to such a structure. Policy and organizational inertia prevent the shift. This thesis will explore and recommend contracting alternatives for government managed health care contracts. It recommends moving beyond the current strict compliance contracts by analyzing more outcome-oriented efforts that foster an incentive to excel and reward innovation.

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MANAGED HEALTH CARE WORK IN FEDERAL GOVERNMENT
PROCUREMENTS**

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"If we don't change our direction, we're likely to end up where we're headed."

-Chinese Proverb

A beneficiary tried in vain to find a TRICARE network provider in her area to treat her swollen knee. On her first call to the contractor's toll-free number, she was given four doctors' numbers; two of the numbers had been disconnected, one belonged to a doctor not accepting TRICARE Standard patients, and one was for a hospital emergency room. The patient tried the toll-free number again and got two more numbers, but neither doctor was working that day (Friday). On her third try, she was given six more doctors' names, but only two came with phone numbers. She was told to look up the other four in the phone book, but none were listed. Of the two phone numbers she received, one was invalid and the other proved to be that of a pediatrician. Thus, after 2-1/2 hours of unsuccessful attempts to find a doctor, she called an MTF she previously had not been able to get through to and was given an appointment that same day.¹

I. Introduction

After two and a half hours on the phone, most people would give up on the managed health care plan, disenroll, and hunt for someone who cared. TRICARE² is in effect across the nation and even my wife even had one of these experiences.. Anyone enrolled in a managed health care plan has enjoyed a similar encounter at some point. Each TRICARE

¹ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: DoD COULD IMPROVE ITS BENEFICIARY FEEDBACK APPROACHES, REPORT NO. GAO/HEHS-98-51 (1998) at 17 [hereinafter BENEFICIARY FEEDBACK]. Congress requested that the GAO study TRICARE beneficiary feedback as a measure of the program's success. *See id.* The GAO study looked to the managed care industry to discover beneficiary feedback is a key management tool. *See id.* The DoD does not effectively use beneficiary feedback techniques in its TRICARE operations for program evaluation or contractor motivation. *See id.* As a result, GAO recommended that the DoD use beneficiary feedback as a key evaluation tool and an outcome measure in the next generation of contracts. *Id.* at 3.

² 10 U.S.C. § 1072 (1997)

(7) The term "TRICARE program" means the managed health care program that is established by the Department of Defense under the authority of this chapter, principally section 1097 of this title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services. *Id.*

contract started with similar problems, many caused by the contractor attempting to fulfill the minimum contract requirements.

Contracting for managed health care systems is a complex undertaking. The current TRICARE contracts captured all the important parts of the system and ensured detailed compliance with the many system requirements. The TRICARE contracts do not allow for system changes and innovation because the specific contract requirements make change almost impossible. In a nutshell, this describes the Department of Defense's (DoD's) managed health care program, TRICARE. A better way must exist to encourage flexibility and incentivize the contractors to care for the health care system's beneficiaries while managing costs.

A compelling alternative to DoD's current, limited strategy of using traditional contract structure and type exists. Performance-based contracting with incentives is the best alternative. No legal or regulatory requirements prevent shifting to such a structure. Policy and organizational inertia prevent the shift.

This thesis will explore and recommend contracting alternatives for government managed health care contracts. It recommends moving beyond the current strict compliance contracts by analyzing more outcome-oriented efforts that foster an incentive to excel and reward innovation.

First, this thesis will focus on an introductory discussion of civilian managed health care and DoD's health program. Second, it will present several relevant incentives delivered through different Government contract types. Third, the thesis will explore the analysis and

structure of incentives in performance-based service contracts (PBSCs)³ in different federal agencies. Most importantly, having identified and discussed the contract types, incentives and recent innovations, the final part of the theses will consider, balanced cost-effective and enforceable government managed health care contract and incentive options. DoD can do a great job with the tools currently available if it is willing to step outside its current, narrowly defined world.

The managed health care landscape requires a healthy basic introduction. explanation. Otherwise, this simply becomes another contract issue without context and ultimately without meaning.

II. Managed Health Care: The Big Picture

Managed health care⁴ is synonymous with rationed health care benefits, perceptions of substandard care, and a blossoming public frustration with managed care organizations (MCOs). It is a tarnished reputation earned by cost cutting and treatment limitations

³ OFFICE OF FEDERAL PROCUREMENT POLICY, A GUIDE TO BEST PRACTICES FOR PERFORMANCE-BASED SERVICE CONTRACTING, FINAL EDITION, OCTOBER 1998. (visited Nov. 23, 1998) <<http://www.arnet.gov/BestP/PPBSC/BestPPBSC.html>> [hereinafter PBSC BEST PRACTICES GUIDE].

Performance-based service contracting (PBSC) emphasizes that all aspects of an acquisition be structured around the purpose of the work to be performed as opposed to the manner in which the work is to be performed or broad, imprecise statements of work which preclude an objective assessment of contractor performance. It is designed to ensure that contractors are given freedom to determine how to meet the Government's performance objectives, that appropriate performance quality levels are achieved, and that payment is made only for services that meet these levels. *Id.* at Foreword.

⁴ PETER R. KONGSTVEDT, THE MANAGED HEALTH CARE HANDBOOK, at 505 (2d ed. 1993). [hereinafter HANDBOOK] This is the seminal text regarding managed health care. It describes some very basic organizational structures and business arrangements that are reflected in the TRICARE contracts. *See id.* There is no single definition of managed care, however, the basic attributes include a system of health care delivery that attempts to manage the cost, quality, and access of that health care. *Id.* at 505.

detrimental to sick people dependent on the system's benefits and good graces.⁵ In spite of the bad reputation, managed care in one of its various forms, is now commonplace.⁶

Managed care did offer cost effective choices for employers and individuals seeking health services they could not otherwise afford. The same rising costs nurturing managed health care's growth in the civilian market afflicted the DoD.⁷ At Congress' behest in Fiscal Year 1993, DoD jumped head-first into the managed health care industry.⁸ Congress mandated a triple option benefit centered on a Health Maintenance Organization (HMO) option to be implemented by MCS contracts augmenting the existing Military Health System⁹ (MHS)¹⁰.

⁵ MICHAEL L. MILLENSON, DEMANDING MEDICAL EXCELLENCE: DOCTORS AND ACCOUNTABILITY IN THE INFORMATION AGE 294 (1997). Millenson's book discusses rising health care costs and the growing tension between cost control, technological advances and the peoples' expectation they will receive healthcare. *See id.*

⁶ Vickie Yates Brown, *et. al.*, *Managed Care at the Crossroads: Can Managed Care Organizations Survive Government Regulations?*, 7 Ann. Health L. 25 (1998). About 58 Million people are enrolled in Health Maintenance Organizations (HMOs) and 81 Million are enrolled in other types of managed health care. *See id.*

⁷ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE, ISSUES AND CHALLENGES CONFRONTING MILITARY MEDICINE, REPORT No. GAO/HEHS 95-104 (1995) at 28, 29. [hereinafter ISSUES AND CHALLENGES] CHAMPUS users grew by 162 percent overall and outpatient visits grew by more than 200 percent from 1981 to 1990. *See id.* At the same time, the direct care system or MHS remained highly utilized or even overused with unnecessary visits. *See id.* A recent DoD study found that beneficiaries use MTF health care services as much as 50 percent more than civilians in similar fee-for-service health care plans, which has been attributed to care being provided free of charge in MTFs. *See id.* The DoD health care budget grew nearly 225 percent between 1980 and 1990 while the CHAMPUS portion of the budget grew by approximately 350 percent. *See id.* This phenomenal growth exceeded even the national health care expenditure growth of 166 percent for the same period. *See id.* Congress directed the GAO report on the entire military health services system, its current state and future significant issues it faced. *See id.* The report is an extensive overview of the entire military system up through the end of calendar year 1994.

⁸ National Defense Authorization Act of 1994 § 731, P.L. 103-160, 107 Stat. 1686 (codified as amended in scattered sections of 10 U.S.C. Chapter 55).

⁹ The Military Health System (MHS) is the entire DoD health care infrastructure including the military treatment facilities (MTFs) and the TRICARE MCS contractor care provided outside the MTFs walls. The MHS spans the gamut from delivering the TRICARE health benefit to supporting the operational and readiness mission. Department of Defense Health Affairs, *MHS Strategic Plan* (visited Jan. 25. 1999), <http://www.tricare.osd.mil>

¹⁰ National Defense Authorization Act of 1994 § 731.

The three benefits are labeled TRICARE Prime¹¹, the HMO option; TRICARE Extra,¹² the preferred Provider Organization (PPO) option; and TRICARE Standard,¹³ the old Civilian Health And Medical Program of the United States (CHAMPUS) indemnity program option. TRICARE is DoD's managed health care program and the harbinger of a national, integrated health care delivery system.¹⁴ Congress dictated that TRICARE be implemented quickly.¹⁵ The DoD immediately put together a team and drafted a requirement for a huge scope of services it had never contracted before.¹⁶ DoD Health Affairs and CHAMPUS admirably captured the basics needed to get the program quickly off the ground using existing program

¹¹ 32 C.F.R. §199.17(a)(6)(ii)(A) (1998). TRICARE Prime, the HMO benefit, is characterized by cost and choice limitations. Each beneficiary is assigned a primary care manager for their routine care and to act as a gatekeeper to specialty care. It also has uniform benefits across the United States with a twelve dollar copay for outpatient care, eleven dollars per day for inpatient stays, an annual enrollment fee for retirees and their families, and no requirements to file claims forms. *See also*, TRICARE MidAtlantic Marketing Brochure, 1998.

¹² 32 C.F.R. §199.17(a)(6)(ii)(B) (1998). TRICARE Extra allows the beneficiary increased provider choice for a higher cost share. If the beneficiary uses the Prime network providers, their cost share is fifteen percent and they do not need to file claims forms. *See also*, TRICARE MidAtlantic Marketing Brochure, 1998.

¹³ 32 C.F.R. §199.17(a)(6)(ii)(C) (1998). TRICARE Standard is the traditional Civilian Health and Medical Program of the United States (CHAMPUS) with the most provider choices and the highest expense. The cost share is twenty to twenty-five percent of the allowable charge. *See also*, TRICARE MidAtlantic Marketing Brochure, 1998.

¹⁴ National Defense Authorization Act for Fiscal Year 1997 § 721, P.L. 104-201, 110 Stat. 2593. It defines TRICARE as DoD's managed care program established under the authority of 10 U.S.C. §1097. *See id.*

¹⁵ National Defense Authorization Act of 1997 §721. The original statutory requirement was to have all the contracts awarded and operational by fiscal year 1997.

¹⁶ ISSUES AND CHALLENGES, *supra* note 7 at 28. CHAMPUS contracted for this type of work before and has limited experience in acquiring and managing health care services. That experience is demonstration projects in limited and defined catchment areas. *See id.* A demonstration project is a CHAMPUS Reform test carried out in the 1980s and early 1990s under Secretary of Defense's authority and at Congress' direction. *See id.* These projects tested new health care delivery concepts and management structures. *See id.* The CHAMPUS Reform Initiative (CRI) represents some of those demonstrations. *See id.* The beneficiary population was limited because the project was for a defined geographic area. *See id.* The project costs were in the millions, and not billions, of dollars. CHAMPUS, now the TRICARE Management Activity (TMA), rapidly moved from these finite demonstration projects to a nationwide managed health care program by passage of a bill. National Defense Authorization Act of 1994 §731. TMA and DoD Health Affairs were ill-prepared for managing such huge, complex service contracts. *See* ISSUES AND CHALLENGES.

and personnel resources. But, it did not fully conceptualize the intricacy of the task that lay ahead.

The Federal Acquisition Regulation's (FAR) acquisition methods and existing managed care demonstration contracts formed the template for this rapidly assembled effort. The CHAMPUS Reform Initiative (CRI) contracts formed the model for TRICARE contract requirements.¹⁷ The DoD envisioned that these contracts would simply run like expanded CRI contracts. It did not foresee that administering these huge contracts would require equally traditional intensive contract oversight.¹⁸ The CRI projects did not require much oversight since the bulk of the required data was collected through claims processing. Consequently, CHAMPUS did not have either the information systems needed to monitor statistical contract performance or the trained personnel infrastructure to monitor the broad range of contract performance.¹⁹ As a contract grows in size and complexity, the problems usually grow in number, size and complexity.

¹⁷ Information on contract development, administration and strategic planning was obtained from historical notes, memoranda, and office meetings. This information is retained with the author and at the Department of Defense Health Services Region IV Lead Agent Office, DoD HSRIV, 111 G Street, Keesler Air force Base, 39534-2428. [hereinafter *DoD HSRIV Historical Records*]. The *DoD HSRIV Historical Records* are materials collected during acquisition development, competition, award, and contract management. Those records addressed health care operations, performance problems and deficiencies, policy issues, political issues, and health care risk issues from 1993 to 1998 for the Army, Navy, and Air Force. *See generally*, U.S. DEP'T OF AIR FORCE INST. 63-124, PERFORMANCE BASED SERVICE CONTRACTS (1 March 1999) [hereinafter AFI 63-124]. This AFI provides examples and guidance for Air Force performance based service contracting. *See id.* Examples and guidance in the regulation is geared to requirements like janitorial services, food services and base maintenance. *See id.* All focus on one location and one limited type of work. *See id.* These efforts require limited government oversight and effort. *See id.*

¹⁸ Most service contracts are discrete, being limited in work and location. Contracting activities typically train and dedicate limited resources that monitor contractor performance. This operational concept is simple to control and manage. Service contracts usually do not encompass a broad range of services and locations. Consequently, service contracts like the MCS contracts require many different oversight activities and specialties needing coordination across the contract's spectrum.

¹⁹ *See generally*, ISSUES AND CHALLENGES, *supra* note 7. Aside from CRI and the CHAMPUS Dental Program, DoD Health Affairs and CHAMPUS was run as an indemnity and benefits program. *See id.* Is expertise lay in

Prescriptive requirements based on old managed care methodologies compound the contract administration complexity. Current TRICARE contracts represent first generation health care service contracts implementing first generation managed health care organization models. TRICARE contracts are prescriptive design specification based contract and are not flexible, outcome based instruments. These rigid documents often require significant statement of work modifications for most business process changes. These organizational requirements and structures are notoriously inefficient and costly.²⁰ For instance, DoD's contracts include an intensive utilization management and preauthorization process designed to monitor provider decision making and approve care provided to the plan beneficiaries. The idea is to ensure care needed by the beneficiary is appropriate and cost effective. This puts a screening process up front in the health care episode. The current industry standard is to "profile" providers through their testing, diagnosis and treatment plans to identify the "high fliers," frequent system abusers relating to certain procedures, and incompetent providers and use that information to educate and train the doctors on appropriate procedures

its benefits administration and claims processing program oversight. *See id.* This oversight amounted to reviewing the data regarding claims payments and rejections and visiting the Fiscal Intermediary's (claims processor) business location. *See id.* For contracts of this nature, oversight can be simple if the performance measurement goals require processing within a specified number of days and there be, for instance, no more than a five percent error rate. *See id.* The Government contract management team can then be centralized and largely restrict its efforts to benefit administration and data analysis. *See id.* This is specifically why CHAMPUS succeeded in managing its early contracts. *See id.* This is also part of the reason for the problems seen in the TRICARE contract administration.

²⁰ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: TRICARE IMPROVEMENTS AND RESIDUAL PROBLEMS, REPORT NO. GAO/HEHS-95-142 (1995) [hereinafter TRICARE IMPROVEMENTS]. The TRICARE contracts dictate minimum requirements, which are overly restrictive limiting the contractor's performance methodology choices. *See id.* The contractors claim that they could save significant costs if the DoD would focus on outcomes rather than process. *See id.* This would allow innovation without affecting the quality of care.

and care.²¹ The industry standard profiling removes administrative obstacles from the provider's and beneficiary's path while focusing contractor utilization management assets on physician behavior. It is a far more streamlined approach than that required under the contract.

DoD's rigid approach is ill-suited to reap the rewards of a constantly changing and developing health care market since incentives do not exist for the contractors to implement system improvements without significant cost impacts. Every change to the prescriptive requirements necessitates a contract modification that may be negotiated and finalized within a year of issuance.²² Consequently, DoD cannot reasonably foster innovation, failing to see the beneficial improvements realized in the current commercial market, the cost savings, and higher beneficiary satisfaction. The dichotomy between DoD's managed care program and

²¹ PATRICIA YOUNGER, ET AL, ASPEN HEALTH LAW CENTER, *LEGAL ANSWER BOOK FOR MANAGED CARE* at 75 (1995) [hereinafter *LEGAL ANSWER BOOK*]. "Utilization Management (UM)" is a key feature to the success of managed care. It essentially refers to methods of coordinating providers and services by monitoring the quality of treatment, identifying quality and cost-efficient providers, finding and reducing inappropriate use of services, and making medical necessity determinations for specialty care. *See id.* UM has several components, including utilization review, treatment and discharge planning, and case management. *See id.* Additional aspects that UM may include are physician profiling and clinical practice guidelines. *See id.*

²² GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: ACTIONS UNDER WAY TO ADDRESS MANY TRICARE CONTRACT CHANGE ORDER PROBLEMS, REPORT No. GAO/HEHS-97-141 (1997) at 2. [hereinafter TRICARE CHANGE ORDER PROBLEMS] Since the first contract was awarded in 1994, the TRICARE Management Activity (TMA) has issued 427 change orders, 357 with cost implications. *See id.* The GAO stated that 85 of these orders resulted in a program increase of \$423 million. *See id.* The average change order settlement time is 340 days from the date of issue from the contracting officer. *See id.* The process is further slowed by TMA's inability to budget or establish meaningful cost estimates. *See id.* Such an untimely process requires substantial Government and contractor time and resources in updating cost proposals and raises costs because the contractor's cost control incentive is reduced. *See id.*

The TMA was scrutinized by GAO because it had in excess of 400 change orders that were not settled as of mid-1997. *See id.* The GAO estimated that of the 223 changes relating to the TRICARE contracts, the DoD potentially owed \$423 Million. *See id.* The GAO criticized TMA's change order management, cost estimating and serious lack of planning. *See id.* These delays run up government operating costs significantly and decreased negotiating leverage. *See id.* The TMA's management problems directly reflect on its contract surveillance and performance management.

the rapidly changing civilian managed health care market continues to grow. That gap needs to close.

A. A Managed Care Background

Like it or not, managed health care arrived with a bang this decade.²³ It rapidly migrated from the west coast's mature markets to blanket the major United States population centers.²⁴ As a result, the industry experienced exponential enrollment growth. For instance, HMO enrollment increased from six million persons in 1976 to 67.5 million persons in 1996.²⁵ Early plans started in the Pacific Northwest logging communities where workers had to rely on friends and relatives for health care support when injured.²⁶ Over time, Americans turned to insurance companies and prepaid health care plans to indemnify their health care which forced those organizations to search for avenues to control their costs.²⁷ Managed health care

²³ American Association of Health Plans (AAHP), *Number of Health Maintenance Organizations...and People Receiving Health Care Through HMOs and PPOs* (visited Jan. 9., 1998), <www.aahp.org/services/library/statistics/plans94.htm>. Enrollment in HMOs almost doubled from 1990 to 1996. *See id.*

²⁴ MILLENSON, *supra* note 5, at 289. Despite bad press and significant legal obstacles, HMOs spread from 33 service 3 million people in 1970 to 9.1 million in mid 1980. *Id.* at 291. The American Medical Association even acknowledged in 1992 that the care delivered by HMOs is of a generally high quality. *Id.*

²⁵ Brown & Hartung, *supra* note 6, at 29. The 1990s saw substantial growth in MCOs. *See id.* For example, 650 HMOs existed in 1994 with 22 new plans in 1995. *Id.* Also, over 1000 PPO plans existed with eleven new PPOs during the same time. *See id.* Noted in AAHP, *Number of Health Maintenance Organizations...and People Receiving Health Care Through HMOs and PPOs*, *supra* note 23.

²⁶ MILLENSON, *supra* note 5, at 287. These first prepaid plans started in the 1800s to ensure care to sick or injured workers and get them back on the job. *Id.* Several doctors in the Seattle area began selling their services to local mill owners for fifty cents per worker per month. *Id.*

²⁷ MILLENSON, *supra* note 5 at 287-294. In 1895, a large United States insurance company tried reducing fees in return for sending doctors a high number of physical exams. *See id.* This was one of the first volume discounts for medical services. *See id.* Prepaid group health clinics continues to grow around the nation. *See id.* In 1929, a clinic offered services to two thousand employees of Los Angeles Department of Water. *Id.* at 288. In the 1920's Kaiser offered a plan in Northern California and other plans began in Washington, D.C., and New York City. MILLENSON, *supra* note 5 at 288. These prepaid plans eventually had to confront resource limits. *Id.* at 292. In the 1980's, the concept of rationing and limits arose because Medicare switched its

organization controls reflect one cost control measure by restricting beneficiary access to care through health plan or benefit administration. With resource limits at the market's forefront, insurance indemnity programs and the HMO's offered services tailored to the beneficiary's finances or the corporation's desire for a more or less comprehensive health plan, in return for periodic payments.

Most health care beneficiaries were accustomed to the traditional fee for service, family doctor care visit. If the doctor determined a procedure or course of care necessary, it happened. Quality care came to mean more care, more testing, and more doctors in many patients' eyes.²⁸ No one looked over the doctor's shoulder, questioning his judgment and requests. He was always right and wore the mantle of absolute authority' the system had no checks to balance the doctors' decisions and discretion. The doctors used more services which increased overall cost. However, increased use is not the sole reason for higher health expenses.

Health care costs also escalated because doctors increasingly relied on expensive tests and procedures. Technological advances and higher malpractice risks also drove expenses higher.²⁹ As a result, health care insurance companies and other health care organizations

payment policies. *Id.* at 292. It began paying fixed rates for procedures. *Id.* Hospitals receiving Medicare payment could continue providing as much care as they wanted, but limited resources brought this practice to a halt. *Id.* Industry began using this practice and HMOs perfected it. *Id.* at 294.

²⁸ MILLENSON, *supra* note 5 at 4. The public believed that extra resources automatically meant improved care. *See id.* The doctors became accustomed to being paid for all the care they ordered.

²⁹ *Id.* at 4

played a larger role in our medical care.³⁰ Employers and insurance companies looked to control expenses and reel in unnecessary procedures by reviewing doctors' decisions and treatments to ensure appropriateness and the use of less costly conservative treatments. Managed care organizations control health care costs through two conceptually simple avenues. First, they limit beneficiary access through plan benefits and premiums. Second, they require physicians to conform their practices to treatment and referral guidelines by reviewing doctor decisions for appropriateness. A wide variety of business organizations grew to implement these controls.

Market forces also gave birth to different health care organizations that manage physicians and provider groups while offering health plan programs to corporations and individuals. Managed care typically comprises HMOs, Preferred Provider Organizations (PPOs),³¹ exclusive provider organizations³² (EPOs), and point-of-service³³ (POS) plans.³⁴ By definition, HMOs initially offered health care to those voluntarily enrolled for a

³⁰ J., Patrick Green, *Essays: Speculations on Managed Care*, 31 Creighton L. Rev. 679, 680 (1998) at 680. A growing health insurance market made more money available to doctors which encouraged increased use. *See id.* Insurance coupled with Medicare and Medicaid's early policies of paying for all care billed by doctors, created a bonanza type of atmosphere. *See id.*

³¹ HANDBOOK, *supra* note 4, at 14. A PPO is a selected group of participating providers through which an employer contracts for health care services. *See id.* Key features of PPOs are a select providers panel, negotiated payment rates, rapid payment terms, utilization of management procedures, and customer choice. *See id.*

³² *Id.* An EPO is similar to a PPO but requires beneficiaries to receive all covered health care services from participating EPO providers. *See id.* Other services simply are not covered or are covered at a very low reimbursement rate. *See id.*

³³ HANDBOOK, *supra* note 4 at 15. A POS plan is a hybrid of HMO and PPO plans with the following characteristics: capitation payments, a withheld amount based on achieving utilization/cost targets, a gatekeeper for referrals and hospitalization, and some coverage for services not covered by the plan, which is usually at a much higher payment by the member. *See id.*

³⁴ HANDBOOK, *supra* note 4 at 13-15.

predetermined amount of money per month.³⁵ A managed care plan generally operates in one of two possible ways regarding the physicians. The health plan either places some portion of the organization's providers at risk for the beneficiary's care and the associated costs, or the plan uses primary care physicians as gatekeepers³⁶ to authorize referrals to specialists.³⁷

Managed health care now represents a standard and is the only way most people can afford any health care. Without the ability to participate in a health plan, most people could not afford a significant episode of fee-for-service care, like long term cancer treatments. Medical advances in technology and treatments will only drive health care cost up in the future.³⁸ People are increasingly living longer lives that put additional burdens on our retirements and our health care needs. Usually, old age care is the most expensive care because it addresses the sickest and longest term care.³⁹ Managed care is likely the main cost control avenue standing between the free market and Government regulation.

B. Managed Care Department of Defense Style

A TRICARE prime enrollee referred by his civilian PCM to a civilian specialist began to receive bills for the care. The managed care support contractor told the enrollee that the civilian doctor was using an incorrect identification number and that the doctor should resubmit the claim. The

³⁵ *Id.* at 500-501. This is a capitated payment system not based on services rendered, but based on membership, with variations by age and gender.

³⁶ *Id.* at 503. "Gatekeeper" is a primary care provider who is required to authorize all specialty care, except for true emergencies. Otherwise, the care is not covered under the plan. Most HMO-type organizations have gatekeepers.

³⁷ *Id.* at 504.

³⁸ MILLENSON, *supra* note 5 at 8.

³⁹ Joseph Shapiro, *There When You Need It*, U.S. NEWS & WORLD REPORT, Oct. 5, 1998 at 66.

enrollee then received a second bill and was told that the visit was being treated as a point-of-service claim (which would require the patient to pay a large part of the bill), even though his PCM had properly referred him. He was later told to disregard the second bill.⁴⁰

Health Maintenance Organizations began earning a well-deserved bad name in the early 1990s. This was epitomized by the character portrayed by Helen Hunt in her tirade against HMOs for keeping her son bedridden because the plan did not cover basic testing for her son's allergies in the movie, *As Good As It Gets*.⁴¹ A number of bad cases fueled this perception. *Wilson v. Blue Cross of Southern California*,⁴² is one of the earliest managed care horror cases. In *Wilson*, Howard Wilson, Jr., was discharged from his inpatient stay at the hospital because his health plan would not pay for the needed care even though his treating physician stated he needed additional inpatient care. He was being treated for major depression, drug dependency and anorexia. Upon his premature release from the hospital, Wilson committed suicide. The California Court of Appeals held there was a triable issue as to whether the insurance company's decision was a substantial factor in Mr. Wilson's death. Previous cases determined that an organization could not make decisions subjecting them to liability sounding in tort law.

To most people, decisions like Blue Cross' are far removed from sanity and totally uncaring – the antithesis of health care. Despite the bad name, HMOs and other managed

⁴⁰ BENEFICIARY FEEDBACK, *supra* note 1 at 17.

⁴¹ AS GOOD AS IT GETS (TRISTAR 1997).

⁴² 222 Cal. App. 3d 660, 271 Cal. Rptr. 876 (July 27, 1990). Cf. *Wickline v. California*, 92 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (July 30, 1990). (Mrs. Wickline had her leg amputated because MediCal refused to approve a required course of treatment. She sued the state for its decision and her loss. Her case was dismissed.)

care organizations did effect a downward cost trend and overall provider optimization.⁴³

Almost eighty percent of managed health care enrollees say they are satisfied with the care they receive.⁴⁴ To an extent, managed care is a success.

The civilian market's successful migration to managed health care and the DoD's need to control health care costs, helped lead the DoD to implement TRICARE's nationwide series of managed health care contracts. Seven Managed Care Support (MCS) contracts, totaling about \$15 billion, were awarded covering the entire continental United States.⁴⁵ All are Firm Fixed Price⁴⁶ contracts with various complicated price adjustment clauses⁴⁷ used to compensate the prime contractor for beneficiary and market fluctuation. Before addressing the contracts, a description of DoD's health care system is warranted.

⁴³ Joseph P. Shapiro, *There When You Need It*, U.S. NEWS & WORLD REPORT, Oct. 5, 1998 at 64. "[M]anaged care's biggest success has been in controlling costs. Health insurance premiums rose just 2.2 percent for 1998."

⁴⁴ *Id.*

⁴⁵ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: OPERATIONAL DIFFICULTIES AND SYSTEM UNCERTAINTIES POSE CONTINUING CHALLENGES FOR TRICARE, REPORT No. GAO/T-HEHS-98-100 (1998) at 3. [hereinafter OPERATIONAL DIFFICULTIES]. Congress directed GAO to review DoD's progress in implementing TRICARE, determine whether DoD is reporting an accurate picture of the program's success, and address what future program changes may do to the program. *See id.* The GAO reported that DoD's reports were overly optimistic, there are recurring problems like cost overruns and poor access, and that projected changes in the downsizing of the military will cause costs to rise further. *See id.*

There are seven contracts covering 11 regions. A Lead Agent Office administers the contract for each Region. These areas cover large geographic portions of the United States taking population distribution into account. In 1994, each Lead Agent was led by a Medical Corps. general officer. The Lead Agent is responsible for administering the health care delivery portion of the contract. The TRICARE Management Activity (TMA) administers the information management, claims processing, and program management portions of the contracts. The Lead Agent has an Administrative Contracting Officer, and the TMA retains overall program management authority. The Lead Agents are distributed between the services as follows: Army-5; Air Force-4; and Navy-2.

⁴⁶ 48 C.F.R. §16.202-1 (1997) Firm-fixed price contracts are not subject to any cost adjustment and they place all risk on the contractor. *See id.* They provide the maximum incentive for the contractor to control costs. *See id.*

DoD's health care system consist of two, often distinct, parts. The direct health care⁴⁸ system and the CHAMPUS or indirect health care system. CHAMPUS started in 1956⁴⁹ which was in all practicality a fee-for-service insurance program.⁵⁰ CHAMPUS beneficiaries were required to pay deductibles and copayments, but never had to pay premiums. In the late 1980s, Congress directed the DoD to initiate a series of demonstration projects due to rising health care costs, claims processing burdens and beneficiary dissatisfaction.⁵¹ Known as the CHAMPUS Reform Initiative (CRI), these programs had many of the same features as the current seven TRICARE contracts.⁵² CRI introduced enrollment,⁵³ utilization management,⁵⁴

⁴⁷ The TRICARE contracts have a Bid Price Adjustment clause that prospectively and retrospectively adjusts the contract price based on an array of established variables. Region 3 & 4 Contract, MDA 906-96-C-0002 and Region 2 & 5 Contract, MDA-97-C-0005, Section G.

⁴⁸ ISSUES AND CHALLENGES, *supra* note at 7 at 19. The direct health care system is the existing active duty military hospital, clinic and medical personnel infrastructure described earlier.

⁴⁹ The Dependents' Medical Care Act of 1956, 10 U.S.C. §2071, *et. seq.*, established CHAMPUS. It was later expanded by the Military Benefits Amendments of 1966.

⁵⁰ TRICARE IMPROVEMENTS, *supra* note 20.

⁵¹ See *id.* at 4. These were the reasons Congress used to justify creating the TRICARE program. *See id.*

⁵² See *id.* The same triple option health benefit was offered. This included options for a health maintenance organization benefit, a preferred provider choice and the existing CHAMPUS option. *See id.*

⁵³ 32 C.F.R. §199.17(o) (1998). Enrollment is the process of becoming a health plan member and selecting a participating provider or group as a primary care manager or gatekeeper. *See id.*

⁵⁴ PETER KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH CARE 123-131 (1995). [hereinafter ESSENTIALS] Utilization management involves a host of system controls like prospective reviews to ensure whether a benefit is covered, and appropriate, concurrent reviews to manage the course of hospitalization; and retrospective reviews that focus on reviewing claims for mistakes and to collect data and pattern reviews to ensure quality outcome and provider feedback. *See id.* Utilization management is conducted in the TRICARE contracts by a nurse. Region 3 & 4 contract, MDA906-96-C-0002 (on file with author).

network referral assistance,⁵⁵ and reduced paperwork.⁵⁶ These CRI contracts formed the basis for the TRICARE contracts resulting from the Fiscal Year 1994 legislation.⁵⁷

TRICARE represents DoD's managed health care program implementation. The MHS offers health benefits to about 8.3 Million people and costs about \$15 Billion annually, making it one of the nation's largest health care systems.⁵⁸ The Defense Health Program is a system with 115 hospitals and 470 clinics worldwide.⁵⁹ It employs about 183,000 military personnel and civilians with about 91,000 more medical personnel in the National Guard and Reserves.⁶⁰ The seven TRICARE contracts are intended to meld the direct and indirect health care systems into one large integrated health care delivery system (IDS).⁶¹

Due to the geographic size and beneficiary numbers, the contracts creating this national IDS are for very large, complex health care services systems.⁶² This type of large scale

⁵⁵ *Id.* at 136. A Referral is an approved recommendation to obtain care with a non-primary care provider or specialist.

⁵⁶ TRICARE IMPROVEMENTS, *supra* note 20, at 4.

⁵⁷ National Defense Authorization Act of 1994 §731.

⁵⁸ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: ISSUES AND CHALLENGES CONFRONTING MILITARY MEDICINE, REPORT No. GAO/HEHS-95-104 (1995) [hereinafter ISSUES AND CHALLENGES] *supra* note 7.

⁵⁹ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: REIMBURSEMENT RATES APPROPRIATELY SET, OTHER PROBLEMS CONCERN PHYSICIANS, REPORT No. GAO/HEHS-98-80 (1998) at 4.

⁶⁰ ISSUES AND CHALLENGES, *supra* note 58.

⁶¹ PETER R. KONGSTVEDT, ET AL, *Integrated Health Care Delivery Systems*, in Essentials, *supra* note 54. With the IDS, DoD is developing a health care plan that integrates the military and civilian physicians, facilities and insurance functions into one organization or system. Hence the term "integrated delivery system" Konstvedt defines an integrated delivery system as one that provides a full continuum of care, which can range from physician and hospital services only, to a system encompassing services such as home health, hospice, skilled nursing, preventive care, mental health, rehabilitation, and/or long-term care. *See id.*

⁶² ISSUES AND CHALLENGES *supra* note 7, at 38-41. Originally, DoD Health Affairs (DOD(HA)) divided the country into 12 regions, each managed by a Lead Agent office to administer the health care delivery portion of the MCS contract. Seven contracts were competed and awarded covering the contract regions.

contracting is not new to the federal Government, but is new to health care.⁶³ A different contract management model borrowed from the contract management professionals in weapons systems would likely benefit the contract administration. The DoD manages its larger, long-term weapons and information systems contracts using a business-like systems management model organization called a Systems Program Office (SPO). A SPO is responsible for a handful of contracts and is made up of a multi-disciplinary professional group dedicated to acquiring and managing the system.⁶⁴ The size, complexity and duration of these contracts dictated developing this SPO structure to support acquisition, management and oversight. Although health care and weapons systems contracts are different, the differences are in the complexity, not in management. Most of the weapons systems contracts are for items, unlike health care services which are for individual services. Weapons systems do not have as many moving parts as the living turmoil of the people in the health care system.

Each of the TRICARE contracts are similar in complexity and are often larger in size than the typical weapons system. MCS contracts are large “systems” contracts for health

⁶³ DoDHSRIV Historical Files, *supra* note 17. The current set of contractors do not represent the largest and most advanced managed health care corporations like Columbia Health Care Systems, Kaiser Permanente, and United Health Care, Inc. Most are alliances of managed care organizations or are corporate offshoots from established health care companies seeking to expand with the Government’s dollars. Humana Military Health Services, Foundation Health Federal Services and Sierra Military Health Services are wholly-owned subsidiaries of a larger corporate parent. Anthem Alliance for Health and Tri-West health care Alliance are partnerships of Blue Cross/Blue Shield organizations from the contract’s geographic area. The established managed health care organizations refrained from competing for the TRICARE dollars because they felt the plan extremely ambitious and it was based on an inflexible older form of managed care that was incompatible with the current business practices. A new approach could garner more competition and better prices with more flexible contract mechanisms.

⁶⁴ See organization structures at websites for The Air Force Training Systems Product Group <<http://tspg.wpafb.af.mil/YW/default.htm>> and the F-117SPO site <<http://www.wpafb.af.mil/asc/yn/pages/orgchart.html>>. Typically, SPOs are made up of an executive office and divisions representing finance, engineering, program management, contract management and development. Structures may vary depending on the system’s purpose. *See id.*

care.⁶⁵ The MCS contractors face a very difficult task that requires integrating into a seamless package: doctors, management, hospitals, benefits advisors, education programs, preventive medicine, claims processing, computer information systems and the beneficiaries.⁶⁶ The degree of integration required varies depending on the location, but the three-part benefit plan⁶⁷ is required in every contract across the nation. These are the first managed health care contracts designed to overlay the entire United States and require the contractors to interact with each other. This integration gives the beneficiary the freedom to travel, move and be covered by the program.

TRICARE has many added complexities, such as covering a diverse and mobile 8.3 million member beneficiary population. Additionally, the MCS contractors must adjust and allow for a changing MHS. That change takes several forms. The DoD is rightsizing⁶⁸ by closing clinics and hospitals to cut costs. When the DoD closes facilities, cuts personnel, or shuts down equipment, the contractor receives the beneficiary workload and associated costs. This drives up the contractor's projected contract performance costs because the military

⁶⁵ Each DoD service has separate "buying" organizations dedicated to competing, awarding and administering large contracts. The SPOs manage a discrete system from cradle to grave. For instance, the T-1A Training Aircraft has aircraft, maintenance and training components that are managed by a main office and two satellite offices. The T-1A SPO had between 50 and 70 multi-disciplinary acquisition professionals with the satellite offices contributing an additional 30 or so individuals. They managed a \$1.2 billion program with defined performance locations. The F-117 SPO manages 54 aircraft and their upkeep and is split into six divisions with a director at the helm.

⁶⁶ Region 3&4 contract, MDA906-96-C-0002 and Region 2&5 contract, MDA-97-C-0005. (on file with author [hereinafter TRICARE Contracts] *See id.* Regardless of the contract, each is divided into tasks. *See id.* Health care providers – organization, operations and maintenance; contractor responsibilities for coordination with the Lead Agents and military treatment facilities; health care services; marketing, enrollment and support services; claims processing; program integrity; fiscal management and controls; management; reimbursement; automated data processing; and start-up and transitions.

⁶⁷ *See supra* notes 11, 12, 13. TRICARE Prime, the HMO; TRICARE Extra, the PPO; and TRICARE Standard, the traditional indemnity program.

⁶⁸ Rightsizing is a DoD Health Affairs term of art for downsizing and infrastructure cutting to accommodate a shrinking military.

personnel, facilities, and administrative support no longer exists. The contractor passes these costs on to the Government through requests for equitable adjustment.⁶⁹

The DoD added to the complexity by awarding two functionally different types of contracts. They attempted to capture cost fluctuations, compensating the contractor for the work and cost variances. Both contract types are firm fixed price with retrospective and prospective price adjustment. Five of the contracts use a Bid Price Adjustment (BPA)⁷⁰ methodology, the remaining two contracts awarded at the close of Fiscal Year 1997 use the Alternative Financing⁷¹ methodology.

These contracts are proving cumbersome and non-responsive to the needs of the health care system, particularly in saving money. Every contract started with rock performance, but matures and sees success in beneficiary satisfaction. But for this success, several problems exist. The contractor and the Government dispute every contract price adjustments not working in their favor. As a result, the contractor focuses on minimum requirements to make a profit from the contract modifications and changes. The focus misses overall system performance and beneficiary satisfaction. Consequently, the Government is not realizing its

⁶⁹ A request for equitable adjustment is a contracting term of art. Whenever the contractor experiences an uncompensated change in performance costs, it can request an adjustment in the contract cost submitting this request to the contracting officer.

⁷⁰ See Region 3 & 4 contract, *supra* end of the note 66, Section G-5. The BPA is a retrospective and prospective contract price adjustment conducted at the base contract period and at the end of each option year thereafter. Each adjustment is subject to almost 3000 variables that are data collection driven from the health care provided both in the MHS and in the contractors' network. The BPA is incredibly complex. The final BPA for each option year is completed 18 months after the start of the option period.

⁷¹ See Regions 2/5 contract, *supra* note 66, Section G-5. In addition, DoD(HA) is instituting enrollment based capitation funding methodologies for the MTFs that are projected for phased implementation beginning Fiscal Year 1998. In these contracts there is a quarterly price reconciliation and adjustment. However, the Government data processing systems cannot support this quick collection, analysis, and sorting of statistics. ISSUES AND CHALLENGES *supra* note 7 at 29. Later version of the Managed Care Support contracts contain a

projected cost savings.⁷² DoD's managed health care program needs a different, carefully tailored contract vehicle to successfully provide managed care services to its beneficiaries.

C. DoD's Managed Care Successes And Failures – Areas Ripe for Improvement.

The MCS contracts range in maturity from about one year old to over five years, the latter being on the verge of recompetition. Some information is available regarding the TRICARE program's successes and shortfalls. After five years, the beneficiaries adjusted to the program. TRICARE is operating across the nation and beneficiaries are receiving health care. There are some successes, but TRICARE has many shortfalls. These shortfalls in program management and operations network development, and beneficiary enrollment provide areas needing improvement and a partial basis for this thesis.

Lower than expected contractor bid prices led to a \$2 billion savings in overall Defense health care.⁷³ Annual DoD beneficiary satisfaction surveys show an overall high satisfaction level.⁷⁴ The MTF outpatient surveys show a higher level of satisfaction than with similar civilian HMOs, but the TRICARE Prime beneficiary survey showed satisfaction levels lower

revised financing methodology that is closer to true capitation. Capitation is a strategy for containing health care costs by allocating resources based on a fixed amount per beneficiary in the population. *Id.* at 42.

⁷² OPERATIONAL DIFFICULTIES, *supra* note 45, at 10. The DoD claims over \$2 billion in savings resulted from the TRICARE contracts. *See id.* But, the GAO notes that the five contracts studied at the time of the report had been modified as many as 350 times. *See id.* Also, the DoD projected saving over \$700 million through the contracts' resource sharing program, but the actual savings are \$36 million. *See id.*

⁷³ OPERATIONAL DIFFICULTIES, *supra* note 45 at 10.

⁷⁴ BENEFICIARY FEEDBACK, *supra* note 1 at 6. Beneficiary satisfaction levels were based on a single visit. *See id.* at 10. The survey measured the beneficiaries' access to care, quality of that care, and interaction with the staff during the visit. The DoD also conducts the telephone surveys. *See id.* at 11. The data shows that beneficiary satisfaction increased in 1996 when compared with a 1994-1995 survey. *See id.* at 7.

than those in the private sector.⁷⁵ Overall, these are rough indicators of program success, but the bottom line is far more complex and reflects greater disparity between success and the current measurement yardstick.

Several key TRICARE program features, such as resource sharing,⁷⁶ changes in the direct health care system,⁷⁷ TRICARE Prime Enrollment, and network shortfalls indicate that costs may exceed DoD Health Affairs initial optimistic projections. Resource sharing alone was estimated to save more than \$700 million over five years.⁷⁸ This number reflected savings excluding the projections from the last three contracts.⁷⁹ As of May 1997, DoD facilities and the contractors entered resource sharing agreements projected to reach only five percent of DoD's overall resource sharing goal.⁸⁰ Neither DoD nor the contractors currently believe that further cost savings can be attained.⁸¹ Several problems stood in the way of meaningfully implementing resource sharing. Other issues also compounded the resource sharing program problems. Lack of clear program policies and guidance, an inability to project agreement cost impacts on military hospitals, no financial incentives to enter the agreements, and military hospital charges affecting capability and capacity all prevented effective

⁷⁵ *Id.*

⁷⁶ 32 C.F.R. §199.17(a)(iii)(A) (1998) Resource Sharing is a program loosely based on the CHAMPUS partnership program, 10 U.S.C. §1086 (1998). In a resource sharing situation under the TRICARE contract, the contractor contributes personnel, equipment or cash with the MTF to more fully utilize available assets. Conceptually, this will increase availability of MTF services and drive down overall health care costs.

⁷⁷ As previously discussed, the direct health care system is DoD's hospital, clinic and personnel infrastructure.

⁷⁸ OPERATIONAL DIFFICULTIES, *supra* note 73 at 10.

⁷⁹ *Id.*

⁸⁰ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: TRICARE RESOURCE SHARING PROGRAM FAILING TO ACHIEVE EXPECTED SAVINGS, REPORT No. GAO/HEHS-97-130 (1997) at 2 [hereinafter TRICARE RESOURCE SHARING]

implementation.⁸² These problems impact all aspects of TRICARE implementation, not just resource sharing because they point to poor program guidance.⁸³

The direct health care system is undergoing incredible change. From Fiscal Year 1995 to Fiscal Year 1997, the military closed 12 hospitals and 29 clinics.⁸⁴ Couple this decline with a lack of consistent data on which the contractors can base proposals, and the information used to describe the military health system becomes very unreliable. The contractors have very little firm data on which to base their proposals. The reduction in facilities is significant in TRICARE because that reduced capacity necessitates that beneficiaries receive care in the contractor's network.⁸⁵ This increases contractor costs significantly in ways beyond the BPA's ability to compensate. These reductions force changes in the overall defense health system that must be captured in significant contract modifications.⁸⁶ Business through

⁸¹ *Id.*

⁸² *Id.* The military health system changed its operating structure so significantly, an increased efficiency to levels that the resource sharing program was no longer effective. *See id.* Resource sharing may not be a viable program if the DoD has no medical personnel or facility resources to share with the contractor. *See DoD HSRIV Historical Records, supra* note 17.

⁸³ *See DoD HSRIV Historical Records, supra* note 17. No program guidance existed for resource sharing until late November 1996, a year after the contract in Regions 3 and 4 started...over two years after the Region 11 contract started. *See id.* TRICARE is riddled with this type of management. *See id.*

⁸⁴ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE: DESPITE TRICARE PROCUREMENT IMPROVEMENTS, PROBLEMS REMAIN, REPORT NO. GAO/HEHS-95-142 (1995) at 3. In Fiscal Year 1995, the DoD had 127 hospitals and 500 clinics; and Fiscal Year 1997, the DoD dropped to 115 hospitals and 471 clinics. This is only a two year representation of the infrastructure cuts. *See OPERATIONAL DIFFICULTIES, supra* note 73, at 2.

⁸⁵ *See OPERATIONAL DIFFICULTIES, supra* note 73 at 12. Even though the health system shrinks, the beneficiaries do not move and still require care. The network is the contractor's health system supplementing the military hospital. *See generally id.*

⁸⁶ *See DoD HSRIV Historical Records supra* note 17. Region 4 experienced several significant downsizing efforts. *See id.* In each instance, the contractor could not simply absorb the changes in its existing network structure and had to make significant adjustments to its business arrangements forcing costs to rise. *See id.*

modification is always expensive and rarely cost effective, since no competition controls the cost. System changes present some of the problems DoD must address.

Enrollment in TRICARE Prime is crucial to TRICARE's success on all fronts. TRICARE Prime beneficiary enrollment allows the Government and contractor to actually manage care; the contractor can manage the beneficiaries' use of health care of services, contain costs by using primary care managers who ensure beneficiaries receive appropriate and necessary care, and reduce beneficiary out-of-pocket expenses.⁸⁷ If enrollment is low, the contractor cannot control costs. As of October 1997, about 57 percent of the targeted beneficiaries enrolled in active TRICARE Regions.⁸⁸ Costs will inevitably increase if DoD and the contractor cannot manage care because it means that the beneficiaries are using the more expensive TRICARE Standard option.

Provider network development is also critical and a task often in dispute.⁸⁹ The contractors' inability to develop and maintain supporting TRICARE Prime networks will negatively impact cost savings. Physicians become quickly disillusioned with managed care when it becomes difficult. They end up dropping out of the program. The following problems are typical of managed care and TRICARE in particular: claims not paid on a timely basis, slow pre-authorizations, unreliable customer phone service and deeply discounted rates.⁹⁰ When these issues cause physicians to drop out of networks, the

⁸⁷ See OPERATIONAL DIFFICULTIES, *supra* note 73 at 5.

⁸⁸ See *id.* at 7.

⁸⁹ See DoD HSRIV Historical Records, *supra* note 17. The contractor's definition of an adequate network differed greatly from the Government's. *See id.* The contractor's goal was to meet what minimum contract requirements, while the Government wanted the contractor to meet the intended requirement. *See id.*

⁹⁰ See OPERATIONAL DIFFICULTIES, *supra* note 73 at 7.

contractor and Government pay increased rates and lose the ability to guide the beneficiary through the appropriate health care wickets. The Pensacola Florida area network disintegrated for a short period of time because the contractor's claims payments were delayed for over six months.⁹¹ Several key provider groups left the network and the enrolled population had no network option for care.⁹²

In many cases, the physicians are willing to accept discounted rates, but the administrative hassles involved in working with a highly regulated Government contractor pose huge disincentives to joining the TRICARE networks.⁹³ Since DoD used restrictive requirements and TMA regulations, the parties focus on little more than minimal contract compliance. Variances are almost impossible to obtain for the contractors and providers to make their work simpler.

DoD's managed health care contracts are an initial attempt at developing a managed health care integrated delivery system.⁹⁴ The TRICARE system is undergoing a dizzying array of changes and adjustments as the contracting parties discover those portions that work and those that do not work. The DoD must find ways to motivate a contractor's

⁹¹ *See id.*

⁹² *See id.*

⁹³ GENERAL ACCOUNTING OFFICE, DEFENSE HEALTH CARE, REIMBURSEMENT RATES APPROPRIATELY SET; OTHER PROBLEMS CONCERN PHYSICIANS, REPORT NO. GAO/HEHS-98-80 (1998) at 3. The rates reflect Medicare reimbursement rates, which are the lowest in the industry. *See id.* Because the DoD beneficiary pool is small when compared to the Medicare pool, the contractor does not have the benefit of numbers to bolster bargaining power. *See id.* As a result, many providers do not have any incentive to work with the TRICARE contractor.

⁹⁴ . LEGAL ANSWER BOOK, *supra* note 21 at 16. An integrated delivery system is defined as one that provides a full continuum of care, which can range from physician and hospital services only, to a system encompassing services such as home health, hospice, skilled nursing, preventive care, mental health, rehabilitation, and/or long-term care

performance. There are two options: Choosing the right contract type and using performance-based incentives. Firm fixed price contracts with prospective and retrospective economic price adjustments are currently used for all seven TRICARE contracts in some form. TRICARE cannot take advantage of managed care's best practices because the contracts are tied to contract terms and not to outcomes.

A better way exists. The DoD can structure award or incentive fees to facilitate quality health care delivery on behalf of the beneficiary. At the same time, the DoD can award the contractor for controlling health care costs and providing top notch services, using an outcome oriented measurement system that can be legally enforced and economically implemented. Performance based service contracting requires the contracting agency to clearly develop, describe and define its goals for the effort to be meaningful. In turn, this will focus the contractor and the Government on desired outcomes as opposed to process compliance and stress key areas of importance to the Government as the basis for incentive fee payments. The challenge is to blend performance goals, incentives and contract type to accurately represent the Government's need. After implementing a new health care system contract the Government will measure it against its financial and beneficiary success – can the system satisfy the Federal Government and the beneficiaries accessing it?

D. Why Use Incentives and What is the End Result?

Performance, cost, and management are broad and important elements in any Government contract, including health care acquisitions. They differ because they purpose is to provide services and health care options directly impacting individual health. The

decisions these MCS contractors make in pursuit of contract compliance and profit directly relate to the beneficiaries' ability to obtain necessary health care.

Managed health care in the United States is far from static both market-wise and cost-wise.⁹⁵ "Change" is the name of this game. Health care services are under huge market pressure to lower and control costs, manage covered lives,⁹⁶ and refine their structure.⁹⁷ The DoD's health plan dictates many requirements without stressing outcome.⁹⁸ In most instances, the TRICARE program sets out the requirement in detail to define its work as opposed to using outcome.⁹⁹ This approach is restrictive at best and is normally counter-productive.

Combining performance and economic incentives into a meaningful contract structured to accomplish a stated purpose can save money and increase customer satisfaction.¹⁰⁰ However, incentives must relate to required results and let the contractor determine the "nuts and bolts" approach.¹⁰¹ The incentives also need to balance cost, performance and schedule to avoid over-emphasis on any single contract aspect.¹⁰² To work properly to all parties' benefit, an

⁹⁵ SHERYL TATAR DACSO, ET AL, MANAGED CARE ANSWER BOOK, 1998 Supplement, 1-12 (1998).

⁹⁶ "Covered lives" is a term of art defining the number of persons enrolled in a health plan or provider network. *See id.* at GL-9.

⁹⁷ *See id.* at 1-4.

⁹⁸ *See* Region 3&4 contract and Region 2&5 contract, *supra* note 66.

⁹⁹ *See id.* at Section C. The contract statements of work use a procedural list of tasks to define each functional area. *See id.* These become a performance and surveillance checklist.

¹⁰⁰ *See* PBSC BEST PRACTICES GUIDE, *supra* note 3 at Chapter 1.

¹⁰¹ *See id.*

¹⁰² *See id.*

incentive must balance a task's difficulty with the Government's benefit.¹⁰³ Incentivizing a contractor is tricky, but when done properly reaps benefits in all elements.¹⁰⁴

When the Government loosens its grip on detailed oversight and contractor management, rewards innovation, cost savings, and excellence, the users and contractors usually benefit. Even if the Government cannot initially save costs, outcome-oriented contracting may encourage more satisfied customers. More satisfied customers will enrollment, enabling greater health care management and education.

Incentives provide an avenue to create flexible, large service contracts that may save significant health care dollars. They focus the contractor on the end result, not on compliance. Outcomes are more important than how the contractor got there. Incentives focus the contractor on excellence, and not on the process and minimum needs. Incentives remove the shackles reigning in contractors' discretion while allowing the Government to get more for its money. Government procurement rules provide the basic tools to make

¹⁰³ See *id.*

¹⁰⁴ See PBSC BEST PRACTICES GUIDE, *supra* note 3 at Chapter 1. The OFPP lists extensive examples of successes from 15 agencies and 26 contracts. *See id.* OFPP claims there was a 15 percent cost reduction and 18 percent satisfaction increase through using PBSCs. One example of this success lies in an example of a systems contract at NASA for the space shuttle program. NASA put contract incentives to work on its Space Shuttle program.

NASA reduced program costs for the Space Shuttle by approximately \$350 million since FY 90 by the use of special contractual incentives. These incentives included special incentive fees, such as award fees for exceptional cost performance, and value engineering provisions. The award fee for exceptional cost performance is used to incentivize the contractor to initiate innovations, cost management, and cost reduction measures that reduce operation costs while maintaining excellent performance. The award fee is earned incrementally during performance and is in addition to and separate from any other fees available under the contract, and is available only when the contractor earns a performance rating of excellent for the award fee period. The amount of the fee earned is based upon a formula established by the contract, and no fee can be earned during any period when the actual contract costs exceed the should-cost estimate. *See id.* at Chapter 3.

performance-based contracts with incentives work. After discussing these elementary concepts, this thesis will apply those tools and concepts to managed health care.

III. Contract Types and Incentives Available For the Federal Health Care Contract

Certain contract types and incentives work more effectively than others when it comes to getting the most contractor performance for the dollar. Successful health care plans do not simply meet minimum performance standards they exceed expectations. The Government's goal in the health care contractor's case is multifaceted. The goals are to motivate the contractor to care for the beneficiary with a robust and user-friendly system, promote innovation in a state-of-the-art managed care system, deliver superb health care and ensure that Government expenditures remain at least cost neutral.

The FAR provides a good starting point for any contract type discussion. FAR policy dictates a two-prong approach: "to negotiate a contract type and price that will result in reasonable contractor risk and to provide the greatest incentive to the contractor for efficient and economical performance."¹⁰⁵ The DoD's MCS contracts do not fall outside the scope of this policy. The issue becomes selecting the right contract type that places the contractor at the degree of risk appropriate for the DoD health care system. Also, the Government should bear some of the risk for requiring a dynamic system while rewarding the MCS contractors for excellent performance. Before capturing the appropriate contract type and incentive package, this thesis will discuss some of the relevant contract types.

¹⁰⁵ Roger McAvoy, *Contract Types, Payment, Financing and Funding*, (visited Nov. 13, 1998) <<http://aflsa.jag.af.mil>> citing GENERAL SERVS. ADMIN. ET AL., FEDERAL ACQUISITION REG 16.103 (June 1997) [hereinafter FAR].

Cost-reimbursement contracts¹⁰⁶ are the best deals for the contractor and the most costly for the Government. The Government bears much of the cost and performance risk. Therefore, the contractor has a low financial loss risk since it is reimbursed for reasonable performance costs regardless of successful completion. However, the Government shoulders a high risk of incurring cost overruns when the project is not satisfactorily completed. The only cost type contracts remotely appropriate for a MCS contract are: Cost Plus Fixed Fee,¹⁰⁷ Cost Plus Incentive Fee,¹⁰⁸ and Cost Plus Award Fee.¹⁰⁹ However, the DoD developed TRICARE contract requirements enough to avoid taking on additional risk using a cost contract.

The FAR guidance states that incentive contracts are appropriate when simple, firm fixed price contracts are not appropriate and when they facilitate meeting the Government's requirement at a lower cost, with improved delivery or technical performance.¹¹⁰ An incentive contract relates the contractor's profit or fee under the contract to its performance.¹¹¹ Incentives are based on reasonable and attainable targets specified in the contract, discourage waste and inefficiency and motivate the contractor to focus on areas it would not otherwise when left to its own discretion.¹¹² With this general focus, the FAR

¹⁰⁶ See FAR, *supra* note 105 at 16.301.

¹⁰⁷ See FAR, *supra* note 105 at 16.306.

¹⁰⁸ See FAR, *supra* note 105 at 16.304.

¹⁰⁹ See FAR, *supra* note 105 at 16.305.

¹¹⁰ See FAR, *supra* note 105 at 16.401(a).

¹¹¹ *Id.*

¹¹² See FAR, *supra* note 105 at 16.401(a)(1) and (2).

permits incentive fee and award fee contracts in both the Fixed Price and Cost-Reimbursement types.

A. Cost Reimbursement Contract Types

When the uncertainties involved in contract performance do not permit accurate cost estimate to use a fixed price contract, cost reimbursement contracts are appropriate.¹¹³ Additional threshold requirements attach to all cost reimbursement contracts. The contractor's accounting system must be adequate to track costs¹¹⁴ and the Government must conduct surveillance¹¹⁵ adequate to assure the contractor's use of efficient methods and cost controls.¹¹⁶ Cost-Reimbursement contracts are a good deal for the contractor and a Government agency unable to define its requirement. But they place burdensome accounting system requirements on the contractor¹¹⁷ and intensive oversight and surveillance requirements on the Government agency administering the contract.¹¹⁸

The cost reimbursement contract pays the contractor reasonable allowable costs,¹¹⁹ for work conducted, and costs related to that work. As the work progresses, the contractor is

¹¹³ *See id.* at 16.301-2.

¹¹⁴ *See FAR supra* note 105 at Chapter 99, Appendix B. Generally, cost reimbursement contractors must be familiar with FAR cost principles and Cost Accounting Standards (CAS).

¹¹⁵ "Surveillance" is a term of art indicating government oversight of the contractor's performance.

¹¹⁶ *See FAR supra* note 105 at 16.301-3.

¹¹⁷ JAMES P> BEDINGFIELD, ET AL., GOVERNMENT CONTRACT ACCOUNTING, 2-20, 21 (1985). Contractors engaging in cost reimbursement contracts with the federal Government must often establish organizations within the company solely to track costs in an acceptable manner.

¹¹⁸ *See id.* at 3-2, 4. This is because the Government must ensure the contractor uses efficient performance methods and cost controls during performance.

¹¹⁹ *See FAR, supra* note 105 at 31.201-3. Reasonable allowable costs are those not exceeding that which a prudent person in competitive business would incur. *See id.*

paid. Sometimes completion thresholds or other milestones are established affecting payments, but is more or less a work, invoice and payment effort. These contracts are not real possibilities for managed care requirements like TRICARE.

Managed health care is beyond the developmental or experimental stage. A cost reimbursement effort is not appropriate since the contractor's performance risk is not high. The FAR advises against using cost plus fixed fee contracts in developing major systems "once preliminary exploration, studies, and risk reduction have indicated a high degree of probability that the development is achievable and the Government has established reasonably firm performance objectives and schedules."¹²⁰ Managed health care does not meet FAR requirements for cost plus incentive fee (CPIF) contracts. The FAR supports CPIF contracts when the Government is in a developmental situation and knows it will acquire an item or service, but cannot pin down exactly how the item will work or the service implemented.¹²¹ Cost plus award fee (CPAF) contracts are ideal when the Government

¹²⁰ See FAR *supra* note 105 at 16.306(a). Cost plus fixed fee contracts provide the contractor with minimal incentives to control costs. *See id.* The Government uses this contract type when the contractor's risk of successful performance is too great. *See id.* The governing regulations clearly indicate CPFF contracts are not suitable for a proven requirement. A MCS contract is an achievable system. The CRI contracts established a baseline while the current TRICARE MCS contracts establish that the concept is viable, if not fraught with obstacles. TRICARE is definitely beyond this stage.

¹²¹ If contract administration simplicity is one of the acquisition goals, CPIF contracts do not fit the bill. The contract specifies a target cost and fee, a minimum and maximum fee and a fee adjustment formula. See FAR *supra* note 105 at 16.405-1. The parties agree to adjust the fee at a later date based on the "relationship of total allowable costs to total target costs." *See id.* These adjustments are intended to provide the contractor an incentive to manage and perform the contract effectively and efficiently. *See id.* The FAR recommends using a fee adjustment formula that is effective in relation to all variations from the target cost. *See id.* Even consider using negative incentive fees where appropriate. *See id.* Systems contracts where it is "highly probable" that the development is feasible are candidates for CPIF contract types. See FAR *supra* note 105 at 16.405-1.. However, the Government must establish adequate performance objectives. *See id.* TRICARE may seem like a developmental effort to its beneficiaries, but it really is not. The program goals, benefits and general tasks are fairly well defined. The implementation is deficient and the Government's cooperation and willingness to enforce contract provisions is lacking. Besides, this relieves the contractor of significant cost responsibility.

cannot define the requirement and target costs.¹²² Requirements based on reasonable historical data and a need that is defined in some basic manner are probably not CPAF candidates.¹²³

The three cost reimbursement contract types are the most likely candidates for the MCS contracts. Each has positive and negative aspects, but none really fits the Government's need for price control and the search for excellence in performance. A fixed price contract type that shifts the risk to the contractor's shoulders is more appropriate. Since cost reimbursement contracts do not fit, this leads to contracts of the fixed-price persuasion.

B. Fixed-Price Contracts

When the Government purchases goods or services of almost any nature, the preferred method is by fixed-price contract.¹²⁴ Contractors undertake the maximum risk and

¹²² U.S. DEP'T OF DEFENSE, DEFENSE FEDERAL ACQUISITION REG. SUPP. 216.404(b) (Oct. 1, 1997) [hereinafter DFARS]. CPAF contracts are designed to provide incentive for a contractor to achieve performance excellence. During the acquisition phase, the base fee amount is fixed as is an award fee plan. *See FAR supra* note 105 at 16.405-2.. The potential award fee amount is determined unilaterally by the Government using a subjective judgment of the contractor's performance in reference to the award fee criteria. *See id.* A COAF contract is appropriate to use when three basic criteria are met. First, the work does not lend itself to objective cost, technical performance schedule incentive targets. *See id.* Motivating the contractor to exceptional performance enhances meeting contract acquisition objectives while giving the Government the opportunity to evaluate performance and the underlying conditions. *See id.* The additional Governmental administrative burden is justified. *See id.* A key to making this type of contract work is giving the contractor feedback at regular intervals so it has the opportunity to improve and understand the performance quality it is supplying. *See FAR supra* note 105 at 16.405-2.. Any evaluation plan must motivate the contractor in the rated areas but not at the expense of performance in other contract areas. *See id.* This award fee is the only incentive for the contractor to control expenditures because a substantial award is available when it meets and exceeds the objectives in the plan.

¹²³ *See DoD HSRIV Historical Records, supra* note 17. Much of the TRICARE contract requirements are based on historical claims data harvested from CHAMPUS claims and stored on CHAMPUS computer data tapes. *See id.* The remaining portion of the work is written based on data collected from the military treatment facilities historical usage depending on the individual criteria developed at that facility. *See id.* No uniform data collection regimen existed prior to and during TRICARE's initial implementation. *See id.* As a result, data is available on which to develop a requirement, but the reliability is somewhat suspect. *See id.*

¹²⁴ *See FAR supra* note 105 at 16.201.

responsibility for cost and performance with this contract type. In return for taking on this risk, the Government defines its minimum requirements with specificity so the contractor is able to easily satisfy the contract requirements. Depending on the requirement's definition and how stable the marketplace, the Government could set a ceiling or target price.¹²⁵ This is done by operation of a contract clause providing for an equitable adjustment or some other revision to the contract price triggered by specified circumstances.¹²⁶

Fixed-price contracts range from firm-fixed-price to fixed-price with economic price adjustments to fixed-price with incentives. Firm-fixed price contracts place all the cost and performance risk on the contractor, while using fixed-price with prospective price redetermination or with an economic price adjustment clause lessens the contractor's risk. Because of an inability to accurately capture future year costs or due to volatile market conditions, these contracts allow for price adjustments. Factored into the fixed price contract type equation are those with incentive fees and award fees. These contracts focus on getting the contractor to do its job better or with excellence.

Basic firm-fixed price contracts require the least Government oversight and contractor overhead since the focus remains on delivering the minimum contract requirement for a price that will not change. This is the contract type with the least flexibility with the most cost and performance risk placed on the contractor.¹²⁷ This minimal involvement fades as the

¹²⁵ *See id.*

¹²⁶ *See id.*

¹²⁷ *See FAR supra* note 105 at 16.202-2. Adequate price competition is usually required unless there are reasonable price comparisons, estimates or minimal performance uncertainties. *See id.* Commercial items or other supplies or services are typically purchased based on definite functional or detailed specifications. *See id.* The administrative burden placed on the contractor and Government are minimal since the contractor has the maximum incentive to control costs and perform effectively. *See id.* at 16.201-1. Firm-fixed price contracts are

contracts become more complex. Fixed price contracts with economic price adjustment and redeterminable price clauses are available to offset unreasonable contractor risk. Each contract type requires the contracting officer to ensure the contractor has adequate accounting systems in place to support price modifications.¹²⁸ A fixed price contract with economic price adjustment provisions is used when the market conditions surrounding contract performance are volatile and the conditions are expected to exist during the contract performance period.¹²⁹ Contracts with redeterminable prices and economic price adjustment clauses are available when market conditions are very dynamic or when important performance aspects are out of the contractor's control.¹³⁰ This pricing flexibility amounts to additional contractor overhead and Government oversight.

ideal for buying supplies and certain well-defined services, but as the work becomes more complex and lacks definition, this contract type becomes less feasible and less advantageous to all parties. *See id.*

¹²⁸ *See FAR supra* note 105 at 16.203-2. for contracts with Economic Price Adjustment clauses. The contractor must submit adequate information establishing the base level for the adjustment and subsequent data verification. *See id.* at 16.205-3.. The contractor's accounting system must be adequate to support the price redetermination.

¹²⁹. *See FAR supra* note 105 at 16.203-2. The EPA clause allows the price to be adjusted upwards and downwards and is usually based on changes in established prices of specified items, changes in the actual costs of labor or material, or changes in costs indexes of labor or material. *See id.* at 16.203-1. The changes will generally result from industry-wide changes or those situations beyond the contractor's control. *See id.* at 16.203-2. To safeguard the Government's interests, the contracting officer is required to ensure the contract's base price does not already include contingency allowances protecting the contractor that will be duplicated by the EPA clause's operation. *See id.* FP-EPA contracts offer the contractor assurances during competition that it will be fairly compensated for its work and provides the incentive for the contractor to compete and not include over-inflated contingencies. The bid or proposal will be more balanced and accurate while representing an initial price that arguably reflects a better bargain since the contractor will not be placed in jeopardy and the contingencies triggering the adjustment may never occur. TRICARE MCS contracts are not based on labor, material or established prices for specific contract end items. The services provided to the Government and the beneficiaries do not neatly fit within this model. Some adjustment of the clause might allow for an EPA provision to work for the MCS contracts.

¹³⁰ *See FAR supra* note 105 at 16.205-2. The idea behind this particular price revision in a fixed-price contract is that the pricing for the base period is probably accurate, but pricing for subsequent contract performance periods is increasingly speculative in relation to the products or services purchased. *See id.* It would be unfair to hold a contractor to a bargain, the parties knew would change significantly in coming years. As with the

The remaining fixed-price contract types require additional administrative burdens, but allow the Government to foster higher performance levels. They are better suited to a complex managed health care system. Fixed-price incentive and award fee contracts do require a contractor to maintain adequate accounting systems to support the additional oversight needed to make and justify the appropriate determinations. However, the benefits outweigh the additional administrative burden placed on the contracting parties.

1. Fixed-Price Incentive Contracts (FPIF)

This is a fixed-price contract allowing profit and final contract price adjustment via a formula.¹³¹ That formula is based on the relationship of the final negotiated cost to the total target cost.¹³² Two types of FPIF contracts are contemplated, one with firm targets and one with successive targets.¹³³ The goal with both forms is to provide a positive profit incentive for cost control and performance while including incentives on technical performance or delivery that has meaningful impact on the contractor's work management.¹³⁴ The firm target version specifies a target cost and profit, a price ceiling and a profit adjustment

EPA contract type, the contracting officer must determine that the contractor's accounting system is adequate to justify and handle the price redetermination. *See id.* at 16.205-3(b). The FAR also advises that the contract can provide for a ceiling price to ultimately shift risk back to the contractor while still accounting for performance uncertainties and their cost impact. *See id.* To qualify for this contract category, the parties must expect unpredictable changes and either have historical data supporting such chaotic, unpredictable changes or have no data available accounting for inflationary projections. In some respects, this is similar to the TRICARE MCS contracts. At the end of each option year and the base year there is a data and price reconciliation period that usually triggers an alteration of the following year's option.

¹³¹ *See* FAR *supra* note 105 at 16.403.

¹³² *See id.*

¹³³ *See id.*

¹³⁴ *See id.* at 16.403(b)(3).

formula negotiated at the contract's genesis.¹³⁵ Once the contractor completes performance, the parties negotiate a final cost and the price is then established by applying the incentive formula.¹³⁶ If the final cost is less than the target cost, the formula allows the contractor a higher profit.¹³⁷ If the final cost exceeds the target cost, the contractor absorbs the difference as a loss.¹³⁸ Alternatively, the successive target version is similar to the firm target, but sets production or performance points for the contractor to reach before negotiating a cost and profit adjustment.¹³⁹ Once reaching this point, the Government and contractor negotiate either a firm-fixed price or a formula for establishing the final price.¹⁴⁰ Fixed-price incentive fee contracts require the contractor to have adequate accounting systems and require the contracting officer to insure these standards are met. These requirements dictate higher contractor overhead and more significant Government oversight.

2. *Fixed-Price Award Fee Contract (FPAF)*

When contractor performance cannot be objectively measured and the Government wishes to motivate a contractor, award fee provisions are clearly appropriate.¹⁴¹ The Government carries and increased burden to survey the contractor and provide periodic

¹³⁵ *See id.* at 16.403-1.

¹³⁶ *See FAR supra* note 105 at 16.403-1.

¹³⁷ *See id.*

¹³⁸ *See id.*

¹³⁹ *See id.* at 16.403-2.

¹⁴⁰ *See id.*

¹⁴¹ *See FAR supra* note 105 at 16.404.

evaluation against the award fee plan.¹⁴² Award fee contracts are used to motivate the contractor to excellence, but require increased Government commitment since the contract's administrative increases, an award fee board must be established and a fee determining official must decide the contractor's final profit.¹⁴³ An added benefit is that the award fee determination is not subject to dispute.¹⁴⁴ Fixed-price award fee contracts reasonably fix the contract price, and allow the Government to seek more than just the minimum performance level – often satisfaction. In health care services it is important to strive to capture the best the contractor has to offer.

C. Contract Type Section Summary

These different contract types offer a wide range of options for health care contracts and can account for many contingencies. This thesis only considers Fixed Price Award Fee and Incentive Fee contracts because the managed care support services are reasonably well defined and the Government has a decent cost estimate. Incentive (Award fees included) contracts provide leverage to obtain higher levels of contract performance excellence and get the product really intended. However, contract type is only a portion of the equation and is a single tool in the acquisition toolbox. When combined with other tools, contract type selection is more effective. Skillfully drafting contract requirements that allow these contract types to work effectively is another important consideration. Performance-based service

¹⁴² See *id.*

¹⁴³ See *id.*

¹⁴⁴ See *Burnside-Ott Aviation Training Center v. Secretary of the Navy*, 107 F.3d 854 (1997), reh'g denied.. Technically, these decisions are subject to dispute. The Court will conduct a de novo review of the contracting officer's determination to decide whether his decision was arbitrary or capricious. See *id.*

contracting offers a blend of acquisition reform, contract drafting, and contract administration that overlays contract types.

IV. Performance Based Service Contracting (PBSC)

The PBSC “movement” is an offshoot of the Federal Acquisition Streamlining Act and the current White House Administration’s move to reinvent Government.¹⁴⁵ It

requires structuring all aspects of an acquisition around the purpose of the work to be performed as opposed to how the work is performed or broad imprecise statements of work. Performance-based service contracting emphasizes quantifiable, measurable performance requirements and quality standards in developing statements of work, selecting contractors, determining contract type, incentives, and performing contract administration, including surveillance.¹⁴⁶

With a successful pilot project under the Office of Federal Procurement Policy’s (OFPP) belt,¹⁴⁷ service contract conversions to PBSCs are now a Government-wide Priority Management Objective as directed by the Director, Office of Management and Budget (OMB).¹⁴⁸

¹⁴⁵ OFFICE OF FEDERAL PROCUREMENT POLICY, A REPORT ON THE PERFORMANCE-BASED SERVICE CONTRACTING PILOT PROJECT, MAY 1998. [hereinafter OFPP PILOT PROJECT REPORT] <[HTTP://WWW.ARNET.GOV/References/Policy-Letters/pbscpilpro.html](http://WWW.ARNET.GOV/References/Policy-Letters/pbscpilpro.html)> (visited on October 16, 1998) At that time, executives of 27 agencies signed an OFPP pledge to use PBSCs. The pilot project was established in 1994 to promote PBSCs. *See id.* The focus was simple services such as computer maintenance, guard services, janitorial services, and aircraft maintenance. *See id.* The resulting 26 contracts showed a 15% cost savings.

¹⁴⁶ Daniel S. Goldin, NASA Administrator, PERFORMANCE BASED CONTRACTING <<http://www.hq.nasa.gov/office/procurement/perfbase/htm>> (visited on Feb. 15, 1999).

¹⁴⁷ Office of Management and Budget Memorandum, Performance-Based Service Contracting (PBSC), May 22, 1998 <<http://www.dot.gov/ost/m60/pbscpbsc522.htm>> (visited on Feb. 15, 1999).

¹⁴⁸ *See* Deputy Undersecretary, Department of Defense (Acquisition Reform), Memorandum For Senior Procurement Executives, Performance Based Service Contracting, July 2, 1998. The memorandum reiterates the OMB Director’s stress on acquisition reform by making PBSCs a government-wide Priority Management Objective. *See id.* The author was unable to locate any Director of OMB dictate regarding such a Priority Management Objective. *Also see*, Deputy Secretary, Department of Transportation, Action Memorandum,

A. *What is it?*

For many agencies, PBSCs are a significant departure from business as usual.¹⁴⁹ Services are typically defined by tasks, not goals. For instance, a custodial contract usually requires the contractor to empty trash cans and polish floors every night after work. This focuses on the daily task-by-task work performed without regard to whether a need for the work actually exists. Specifying how the contractor accomplishes the work also fails to address the work's quality. Unfortunately, this statement of work type incentivizes the contractor to complete the bare minimum. It also ties the Government's hands when enforcing contract compliance to the bare minimum described in the contract. Performance-based service contracts are the opposite of this approach. The PBSC describes work and surveillance in terms of outcomes and tasks. Specifically, no attempt is made to define the process, since the contractor crafts the completion method.¹⁵⁰ The OFPP suggests and participating agencies used contract incentives in conjunction with PBSCs to motivate excellence and cost savings.¹⁵¹

Each agency seeking to use PBSCs as an avenue of acquisition reform discovered that it requires a global reassessment of the procurement effort and a huge change in direction from current service contract efforts. The agencies had to develop new performance work

Performance-Based Service Contracting Program, January 4, 1999
<<http://www.dot.gov/ost/m60/pbse/pbse.htm>> (visited on February 15, 1999).

¹⁴⁹ Steven Kelman, (IT) Innovative Procurement: Making the Case for Performance-Based Service Contracting, (visited February 15, 1999) <<http://www.fcw.com/pubs/fcw/1998/0601/fcw-oped1-6-1998.html>> . Procurement lead times increased 70 % for the pilot projects involving professional and technical services. Lead times increased because the agency redrafted the requirements and developed new, integrated teams to develop the procurements. *See id.*

¹⁵⁰ *See* PBSC BEST PRACTICES GUIDE, *supra* note 100 at Chapter 4.

¹⁵¹ *See id.*

statements, performance standards, and quality assurance plans.¹⁵² However, the potential rewards for implementing PBSCs are spectacular. Of the fifteen agencies participating in OFPPs pilot project, there was an overall 15 percent savings in nominal dollars,¹⁵³ a 20 percent rise in customer satisfaction,¹⁵⁴ and an increase from 5.3 to 7.3 in the average number of offers.¹⁵⁵

Performance-based service contracting is simple to discuss, rewards the contractor and agency, but is difficult to implement. It represents an acquisition community culture change.¹⁵⁶ When the Government buys services now, it must accurately define its requirement, how to accomplish the requirement and specify the delivery and performance requirements.¹⁵⁷ Performance-based service contracting represents a significant change in the Government's business strategy for service contracting. It is a tough change, but a beneficial change.

B. Defining the Performance-Based Services.

The statement of work or performance work statement is the crux of the PBSC. The performance work statement establishes the objectives, the quality assurance plan, the

¹⁵² See OFPP PILOT PROJECT REPORT, *supra* note 145.

¹⁵³ See *id.*

¹⁵⁴ See Steven Kelman, *supra* note 149.

¹⁵⁵ OFPP PILOT PROJECT REPORT, *supra* note 145

¹⁵⁶ See *id.*

¹⁵⁷ See FAR *supra* note 105 at 37.602. The FAR rules on performance-based service contracting are in this section. These provisions encourage using performance incentives and performance-based contracting methods. *Id.* at 37.602-4.

incentives and ultimately, a contract's success or failure.¹⁵⁸ The overall goal is to tell the contractor what has to be done, not how to accomplish a task.¹⁵⁹ This is best done by stating the requirements in objective terms, giving the contractor the responsibility of achieving the end result and the freedom of determining generally how that result is achieved.¹⁶⁰

Sometimes it is impossible to measure requirements objectively and the government must judge compliance subjectively.¹⁶¹ In other cases, the government may need to prescribe detailed steps to obtain needed results or support a specified program.¹⁶²

To define a statement of work, the OFPP recommends conducting a job analysis.¹⁶³ This involves defining the government's requirements and the services and outlets demanded of the contractor.¹⁶⁴ Seven basic components make up defining the performance-based statement of work: organization analysis,¹⁶⁵ work analysis,¹⁶⁶ performance analysis and

¹⁵⁸ PBSC BEST PRACTICES GUIDE, *supra* note 100 at Chapter 5. The quality assurance plan "defines what the government must do to ensure that the contractor has performed in accordance with the performance work statement performance standards." *See id.*

¹⁵⁹ Department of Energy, PERFORMANCE-BASED CONTRACTING GUIDE. June 1998, at Chapter 1.3. <<http://www.pr.doe.gov/9808atc.htm>> [hereinafter DOE PBSC GUIDE].

¹⁶⁰ *See id.* at Chapter 2.2.B.

¹⁶¹ *Id.* at Chapter 2.3.

¹⁶² *See id.* at Chapter 2.3.C.

¹⁶³ *See* PBSC BEST PRACTICES GUIDE, *supra* note 100, at Chapter 3.

¹⁶⁴ *See id.*

¹⁶⁵ *See id.* This is a top-level Government review intended to identify the services and outputs required and the overall strategic objective. *See id.* Much of the effort is to focus on the contractor's outputs while intentionally avoiding defining process. *See id.*

¹⁶⁶ PBSC BEST PRACTICES GUIDE, *supra* note 100, at Chapter 3. Next, take the services and outcomes identified in the Organizational Analysis and break down the work into its most basic parts. *Id.* This breakdown provides an opportunity to define the relationships between the parts, clarify ambiguity and ultimately enhance enforcement. *See id.*

standards,¹⁶⁷ directives analysis,¹⁶⁸ data gathering,¹⁶⁹ cost analysis,¹⁷⁰ and incentives.¹⁷¹

When taken as a whole, the job analysis process provides the standards for performance, developing the statement of work, the quality assurance plan and the evaluation indicators.¹⁷² Clearly, this is an extensive, introspective review of the Agency's requirement and what it

¹⁶⁷ PBSC BEST PRACTICES GUIDE, *supra* note 100, at Chapter 3. At this stage, the Agency establishes the performance levels for each task. *See id.* It necessarily determines how the service will be measured and the relevant maximum allowable error rate. *See id.* Under no circumstances should that standard be set at 100 percent since that level of performance is costly. *See id.* The Department of Energy (DOE) recommends publishing the standards to obtain industry input ensuring they are realistic and effective. *See id.* The OFPP suggests using the Request for Information (RFI) process set out in FAR 15.405. *Id.* The RFI process uses public and industry meetings, comments on the proposed standards and draft requests for proposals. PBSC BEST PRACTICES GUIDE, *supra* note 100, at Chapter 3. This part of the process allows for a certain amount of refinement and industry buy-in that proves invaluable later in contract administration.

¹⁶⁸ PBSC BEST PRACTICES GUIDE, *supra*. Note 100 at Chapter 3. Every Agency is burdened with directives, rules and regulations. As a part of accomplishing the Agency's mission, it usually passes these rules on to its contractors. Directives analysis affords the Agency an opportunity to sort through what applies, what is useful and what prevents the contractor from accomplishing its job. *See id.* An Agency should limit its use and inclusion of directives and regulations. Over application causes: "confusion or errors in performing work; undermining the government's ability to enforce required performance; unjustifiable increases in the cost of performance; unwarranted dictation of how work is to be performed, and discouraging or preventing contractor use of innovation or cost-effective performance methods." *See id.* The goal is to minimize using these necessary Agency directives to excerpted portions and avoiding unnecessary inclusion. *See id.*

¹⁶⁹ PBSC BEST PRACTICES GUIDE, *supra*. Note 100 at Chapter 3. Primarily, this relates to workload data. The main source will come from historical records and will be used to estimate future performance requirements and costs. *See id.* Accurate data is crucial to competing offerors since it enables realistic cost estimates and sets performance measurement expectations. *See id.* Without accurate workload data, cost estimates for the Government and the contractor will be flawed. This is a sure recipe for contract performance problems and litigation.

¹⁷⁰ PBSC BEST PRACTICES GUIDE, *supra*. Note 100 at Chapter 3. Cost estimates are central to the Government's requirement, contract type selection, evaluation, performance goals and incentive structures. *See id.* When contracting for commercial services, the Government must consider the commercial cost of providing services in its independent government cost estimate. *See id.*

¹⁷¹ PBSC BEST PRACTICES GUIDE, *supra*. Note 100 at Chapter 3. Positive and negative incentives should be used to motivate high quality performance. *See id.* The trick to incentives is applying them in a meaningful manner, balancing their application so as to avoid negatively affecting performance in non-incentivized portions of the contract. Negative incentives should result in a deduction corresponding to the value of the lost service. *See id.* Positive incentives must be reasonably attainable yet challenging. *See id.* The goal is to reward the contractor for exceptional work and avoid penalizing for satisfactory but not outstanding work. *See id.* According to OFPP, incentives are great for high-dollar value contracts or those that have performance or cost overruns. *See id.*

¹⁷² *See id.*

really needs. A job analysis also represents a grappling with meaningful measurement criteria and a clear definition of expectations.

C. Incentives... Understanding And Defining Performance.

Successful contract incentives have two basic characteristics. First, the performance work statement clearly communicates the work to the contractor and the performance measures are reasonable and attainable.¹⁷³ Second, the incentives motivate performance not otherwise emphasized.¹⁷⁴ These both avoid inefficiency and waste.¹⁷⁵ Keeping this in mind, it is key to mold the incentives to the performance-based approach. A cross-functional team including the technical, management, contracting and offerors is invaluable to defining accurate and reasonable performance measures and corresponding incentives.¹⁷⁶ The team must decide on the performance measures that will be incentivized. These fall into three classes:

- 1) Those significant performance measures for which the desired performance will achieve, but not exceed, the specific performance level stated in the SOW;
- 2) Those performance measures for which the desired performance would exceed the performance level stated in the SOW (performance which would directly benefit the government); and

¹⁷³ DOE PBSC GUIDE, *supra* note 159 at Chapter 4.1.C.

¹⁷⁴ *See id.*

¹⁷⁵ *See id.*

¹⁷⁶ *See id.*

3) Those performance measures which are remedial in nature.¹⁷⁷

Once the team identifies those performance aspects and measurements for incentives, the next issue becomes, how does the Agency rate and judge the performance? Three basic rating categories are commonly used: objective measures, subjective measures, and a hybrid of the two.¹⁷⁸

Objective performance measures are usually specific and lend themselves to measurement, can be validated, and are quantifiable.¹⁷⁹ For example, all phone calls to the Health Care Information Line or the TRICARE Service Center must be answered by a person within two minutes. The requirement is clear. If the contractor fails to answer the call within the stated time, it does not receive an incentive. Subjective performance measures usually cannot be easily quantified, objectively measured or are subject to change beyond the contractor's control.¹⁸⁰ Contractor management integration with the military hospitals and the Lead Agent offices does not lend itself to easy measurement. The Government views measuring how many meetings the contractor attends, reports it files, or letters the contractor sends as

¹⁷⁷ DOE PBSC GUIDE, *supra* note 159 at Chapter 4.2.C. A significant performance measure is one that is critical to other measures, is complex, highly visible, or politically sensitive. *See id.* For example, politically sensitive tasks in TRICARE would be adequate network development or proper claims payment. Anyone depending on a contractor that failed to maintain and hold a network together after initially establishing one understands the community interest network failure generates. Often, the providers and beneficiaries complain to their Congressional Representatives which draws more attention to the problem. Claims payment problems also create high media profile situations when beneficiaries receive bills and doctors do not get paid. These people usually go to Congress and the Press, calling attention to the TRICARE and managed health care system's failure. Remedial performance measures direct a contractor to address unsatisfactory performance areas and those areas where continued poor performance might jeopardize contract success. Phone access to the contractor's Health Care Information Line (HCIL) for advice is a typical start-up problem in all the TRICARE contracts. If the DoD wished to alleviate that problem in future contracts, it should consider applying incentives against full operational capability for the HCIL on the first day of performance.

¹⁷⁸ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.C.

¹⁷⁹ *See id.*

¹⁸⁰ *See id.*

unimportant. However, it is important how effective the contractor's efforts are at working with the Government. Measurement serves no purpose in this instance, but a subjective view of a good working relationship does indicate success. Hybrid or combination performance measures bring together parts of both to capture quantifiable parts of a task while providing the flexibility to capture the non-quantifiable risk and make allowances as appropriate for unforeseeable program changes.¹⁸¹ Network development and maintenance serves as an example of a hybrid performance measure in TRICARE. Beneficiary to TRICARE Prime provider ratios, mileage to provider offices, claims processing times, payment amounts, cost savings per procedure when compared to non-managed health care all represent objectively measurable tasks. Ratios, mileage, and claims processing times established minimum performance levels. However, portions of network development like provider satisfaction with contractor support are not measurable. Adequate contractor support and education impact this satisfaction, but no measurable effort determines satisfaction.. Some work elements are measurable, but the overall Government goal of provider satisfaction and remaining part of the network is not easily measured. Simply establishing the performance measurements is but one element in the process.

The next step requires establishing work and incentive priorities to put the contract requirements in context for the contractor. Assigning weights or fee amounts to the incentivized performance measures indicates the degree of importance in which the agency holds that requirement.¹⁸² The goal is to avoid focusing the contractor on one area at the expense of other performance areas in establishing the relative importance of the incentivized

¹⁸¹ See *id.*

¹⁸² DOE PBSC GUIDE, *supra* note 159 at Chapter 5.3.

performance measures.¹⁸³ The DOE found it important to structure incentives to ensure that the necessary non-critical work is satisfactorily accomplished before the incentive can be earned.¹⁸⁴ Otherwise, contractors ignore less critical but necessary tasks and focus on incentivized performance measures.¹⁸⁵ This step places the incentives in contract in line with the overall contract purpose, but does not determine the evaluation method for the prioritized performance areas.

Metrics offer an objective manner against which to measure a contractor's progress and expectations.¹⁸⁶ Metrics are the measuring tools and they provide an objective method to measure contractor performance levels.¹⁸⁷ A contractor can potentially earn additional incentive fee for early completion, exceeding the performance measurement metric, or delivering services of a higher than required quality.¹⁸⁸ Any performance that fails to meet the minimum metric will not receive a fee.¹⁸⁹ The incentive structure may provide for negative incentives if critical benchmarks are not met.¹⁹⁰ To ensure the contractor applies its efforts sufficiently against the non-incentivized contract areas, the contract should include a

¹⁸³ *See id.*

¹⁸⁴ *See id.*

¹⁸⁵ *See id.*

¹⁸⁶ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.4.

¹⁸⁷ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.4.A.

¹⁸⁸ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.4.B.

¹⁸⁹ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.4.A.

¹⁹⁰ *See id.*

“Conditional Payment of Fee” clause.¹⁹¹ The idea is to permit subjective downward fee adjustment when the unincentivized areas endanger successful performance on the whole effort.¹⁹² In this way, the agency can guide the contractor and realize the cost, schedule or performance benefits when it delivers across the board with excellence.

D. Considerations for Structuring and Drafting Incentives.

A wide range of incentive structure options is at the Government’s fingertips. Each incentive’s appropriateness depends on the facts of the situation. Incentives can be subjective, objective, or a hybrid of both.¹⁹³ They can relate to performance, schedule, management and cost.¹⁹⁴ Once the agency determines what it will incentivize and how it will evaluate the work for the incentive, it must determine how it will structure the incentive. The choice is to structure them either incrementally or continuously.¹⁹⁵ Whether or not an incentive works, depends on several factors. These factors include the contractor’s and government’s benefit, competing incentive priorities, actual incentive fee values, whether the

¹⁹¹ *See id.* “This clause allows for the adjustment of fee (associated with incentivized performance measures) in the event the performance of unincentivized requirements is so poor as to jeopardize the overall performance of the contract.” DOE PBSC GUIDE, *supra* note 159 at Chapter 5.4.C.

¹⁹² *See id.*

¹⁹³ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.C.

¹⁹⁴ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.D.

¹⁹⁵ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.E. An incremental incentive is appropriate for both performance and cost incentives. *See id.* It allows the government to encourage more or additional performance when the contractor beats a metric or a cost goal and reward the contractor each time it performs an increment. *See id.* A continuous incentive allows the contractor to receive incentive payments even though it does not meet a metric. The idea is dangle a carrot in front of the contractor encouraging it to meet the metric in the future, while the enabling the government to receive a benefit from continued performance.

incentives are balanced, and whether the fee can roll over to remain available for a later fee earning opportunity.¹⁹⁶ Each consideration requires a short explanation.

1. Incentive Categories

Incentive categories describe how the Government will evaluate the contractor's performance. These categories help establish the baseline measurements and descriptions of success the contractor must achieve to be eligible for an incentive. Effective performance requires the contractor to understand the Government's evaluation process and measurement tools. Subjective, objective and hybrid incentive categories are fully defined in the health care context below.

When the Government cannot define performance accurately, subjective incentives are appropriate.¹⁹⁷ In this situation, the Government judges the contractor's performance and the surrounding facts against the stated objectives.¹⁹⁸ An example of an immeasurable health care performance area is the MCS contractor's program management. The DoD wants the contractor to manage its operations so that care complements the military direct health care system, promotes hospital operations, and seamlessly integrates with the civilian health care networks. This requirement is not measurable, but gaps in communications between the contractor and Government show failure like coordination and free flowing information show success. But, the Government must rationally base its fee award or incentive determination on the contractor's performance and establish the evaluation criteria during the contract's drafting stage. Otherwise, the contractor will be at a loss in this partnership.

¹⁹⁶ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.

¹⁹⁷ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.2.E. and Chapter 5.5.C.

Objective incentives attach to well-defined tasks accompanied by quantifiable measures.¹⁹⁹ The contractor earns the incentive when it meets the specified goals or exceeds the specified goals.²⁰⁰ For example, an objective measurement in a managed health care setting is when the Government requires the contractor to enroll twenty five percent of the eligible beneficiaries in a specific population area. The Government determines areas' CHAMPUS eligible population from a combination of the Defense Enrollment Eligibility Reporting System (DEERS) or from the claims database. When the contractor meets the twenty five percent goal, it receives the objective incentive. These are simple triggered by a defined event.

Hybrid incentives contain a mixture of subjective and objective incentives.²⁰¹ A simple hybrid incentive example is implementation of an acceptable Utilization Management/Quality Management oversight program by the start of health care delivery. The program's start date is clearly established and evaluated by implementation, but the oversight program's acceptability is determined by subjective measures. Many MCS contract requirements fall in the hybrid incentive category.

2. *Incentive Types*

¹⁹⁸ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.C.

¹⁹⁹ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.2.F.

²⁰⁰ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.C.

²⁰¹ *See id.*

Incentive types help define what the Government is measuring or evaluating. All incentive types are subjective, objective, or a hybrid, depending on the nature of the work.²⁰² Performance, management, schedule and cost represent different possible incentive types. The work subject to incentive dictates the incentive type used and the measurement or evaluation tool the Government uses.

Performance incentives attempt to motivate the contractor to exceed the baseline contract performance requirement, make a significant performance correction or complete a very significant baseline task.²⁰³ Claims processing times are an example of a health care task subject to a performance incentive. For instance, a contract may require the contractor to process claims in thirty days. A shorter processing time benefits the Government through higher levels of customer satisfaction. The Government develops incentives for a contractor processing claims in less than twenty-five and less than twenty days. The Government rewards the contractor's increased performance since it exceeds the baseline performance requirements.

Schedule incentives relate to delivery of goods or services, completion of a task or accomplishing an important milestone by a specific date.²⁰⁴ Plan and report submittals fall in this category. Any health care related schedule incentive is difficult to envision since they are not schedule driven services. If the Government chooses to use schedule incentives, it

²⁰² DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.D.

²⁰³ *See id.*

²⁰⁴ *See id.* The DOE states that schedule incentives "are of questionable value." *See id.* Schedule incentives focus the contractor on early or ambitious completion at the expense of quality performance. In this event, the Government gains little in receiving substandard work.

must condition award on completing all necessary performance measures.²⁰⁵ Obviously, the concept is to prevent the contractor from substandard performance on other related contract tasks.

In contracts with a significant contractor management requirement, management may be a ripe area for subjective incentives.²⁰⁶ The Government evaluates the “contractor’s overall judgement,” responsiveness to its beneficiary and military clients, and the support it offers to those clients.²⁰⁷ Few objective measures accurately capture management’s value. Management incentives are often subjective because it is a function inherent in other tasks and incentives and is difficult to accurately measure. A health care management incentive would focus on evaluating the effectiveness of the contractor’s subcontractor management, its integration with the military hospitals, its network provider management, and its Utilization Management/Quality Management function. Subjectively evaluating management in these areas according to descriptive ratings makes sense and provides the Government a tool for focusing the contractor’s efforts on an important function.

Objective measures best define costs and cost incentives since they give the contractor a firm goal.²⁰⁸ The work must be defined and estimated, a fair baseline negotiated, the contractor must have an adequate accounting system to track applicable costs, and the

²⁰⁵ *See id.*

²⁰⁶ *See id.*

²⁰⁷ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.D.

²⁰⁸ *See id.* Subjective cost evaluations are not effective because they are difficult to verify. *See id.* Goals like “perform cost effectively,” or “reduce costs” do not provide a performance baseline or goal and do not allow for any comparative evaluations. *See id.*

contractor and Government must agree to a cost-sharing plan for savings and overruns.²⁰⁹

Incentivizing costs requires that the contractor and Government have adequate cost tracking capabilities. Each party must allocate expenses to prove whether the cost goals were met or exceeded during contract performance. A good example of a TRICARE cost incentive is in the law. TRICARE's authorizing statute requires the program be cost neutral.²¹⁰ An objective cost incentive based on the contractor keeping costs neutral or within a five percent variation, would be simple to determine and easy for the contractor to target.

Incentive type is mainly important in the planning process since it helps focus the Government and contractor on the work, understanding the incentive, and establishing goals. After determining the incentive type, the agency must consider how it will work.

3. Incentive Structure

Two basic incentive structures exist: incremental and continuous. Incremental incentive structures work when reaching established performance or cost increments.²¹¹ The Government can establish set or periodic milestones that trigger an incentive to reward the contractor appropriately during performance. For example, when the health care contractor establishes a provider network, it requires some maintenance to support long term success.

²⁰⁹ *See id.*

²¹⁰ National Defense Authorization Act of 1994 § 731, Pub. L. No. 103-160, 107 Stat. 1695 (Codified as amended in scattered section of 10 U.S.C. Chapter 55).

(c) Government Costs. - The health benefit option required under subsection (a) shall be administered so that the costs incurred by the Secretary under each managed health care initiative that includes the option are no greater than the costs that would otherwise be incurred to provide health care to the covered beneficiaries who enroll in the option. *Id.*

²¹¹ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.E.

Continuing updates and education must occur periodically for providers to remain competent, contributing members. Incrementally incentivizing updates and education sessions helps achieve better health care delivery and smoother network operations. Continuous incentives are also an option where the government desires a high, sustained level of effort or it receives a benefit from lower performance levels, but wants the contractor to continue striving for higher performance.²¹² For example, the contractor only needs to schedule beneficiary appointments for routine care within seven days. However, the government benefits by lesser wait times with higher beneficiary satisfaction and possibly higher enrollment when the appointment wait times dropped. The government receives a benefit by the contractor's continual attempts to beat that time on average every month. Whether the government chooses to use incremental or continual incentives will depend on the work and the government's objectives. However, incentive development demands some care and planning. The government must soundly consider the proposed incentives and keep the remaining contract requirements in perspective.

4. Other Considerations

While the preceding discussion provides guidelines for developing incentives, some additional considerations overlay common sense on incentive structures. Incentivizing all work elements makes contract administration overly complex and begins confusing goals. The closer to 100 percent compliance or maximum performance produces little return for the effort expended.²¹³ The government must seek to strike a balance between complexity and

²¹² See *id.*

²¹³ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.G.

effectiveness. Likewise, the incentives should be simple as possible and offered for the key tasks needed for a successful program.²¹⁴

The government must carefully weigh selected tasks for incentives against the other incentivized and unincentivized tasks in the contract.²¹⁵ This is important because the government will not incentivize the entire contract, which makes some performance requirements less profitable. The contractor may minimally perform many of the non-incentivized work elements, since it cannot earn any additional profit. Composite subjective incentives or incentive gateways conditioned on successful completion of the unincentivized contract portions should address the remaining tasks.²¹⁶

When the government develops the incentives, it must allocate the fee amount available according to the effort the contractor expends and the success the contractor achieves.²¹⁷ If the return is high or the accomplishment significant, the incentive should be correspondingly high. If the return is insignificant or low, the incentive should also be low. The requiring activity can develop subjective and objective incentives in most complex contracts that accurately reflect the work the contractor performs and its value.

²¹⁴ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.H. To incentivize too many tasks or make them overly complex leads to confusion. The contractor receives mixed messages regarding what tasks are truly important. *See id.*

²¹⁵ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.I.

²¹⁶ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.N. Allowing the contractor to receive incentive payments, but fail on baseline contract performance areas is counter to the overall objective sought by the government. Failure to perform does not accomplish innovation, cost savings and excellence. *See id.*

²¹⁷ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.J.

An incentive big picture view is critical to maintain a balance between subjective and objective incentives.²¹⁸ The objective incentives provide the contractor with a fixed set of requirements described by well-defined metrics to target and earn.²¹⁹ The contractor can target this profit with some certainty provided the measures are realistic. Countering this certainty, the subjective and hybrid incentives provide the government flexibility in determining the contractor's performance success in areas not easily measured.²²⁰ Measuring subjective incentives involves judgement and discretion, permitting the government to consider other facts bearing on performance success.²²¹ Too many objective incentives will remove significant flexibility from the Government's discretion.²²² Contractor's clearly prefer objective measures because they are fixed, but the government needs the ability to evaluate the contractor based on more facts.

Incentive fund availability is determined by the appropriation, but the money for unearned fees remains available at least during that same fiscal year. Allowing unearned incentive to roll over and remain available for later fee determinations provides the contractor an opportunity to continue trying to earn the missed incentive and correct previous performance failures.²²³ Rolling fee over to the next evaluation period allows the

²¹⁸ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.K.

²¹⁹ *See id.*

²²⁰ *See id.*

²²¹ *See id.*

²²² *See id.* Fixing the amounts allows the contractor to target certain incentives at the expense of the remaining tasks. Effectively, this limits the government's ability to motivate the contractor on the remaining work. Discretion and flexibility motivate the contractor to a broader focus. *See id.*

²²³ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.L.

Government the opportunity to encourage completion or improvement.²²⁴ Roll over should focus on tasks and performance measures that can realize a value in succeeding performance periods.²²⁵ The government can structure fee roll over as appropriate for important tasks to avoid wasting the money's allure.

Finally, the incentive payment needs provision or condition ensuring continued excellence. The government can consider making incentive fee payments provisional or conditional.²²⁶ The intent is to condition fee payment on successful task completion and pay the contractor for interim success.²²⁷ A conditional fee payment clause allows for repayment of potentially undeserved or unearned fee when the overall performance is lacking.²²⁸ Most of the incentive payment should be final, since it ultimately reflects a benefit received by the Government.²²⁹ However, the redeterminable part of the incentive payment provides some contractor incentive to keep its quality high.²³⁰

E. Bringing PBSCs Back Together.

²²⁴ *See id.*

²²⁵ *See id.* Typically, a sequential type effort that builds on prior effort or a repetitive effort is ripe for rollover. *See id.*

²²⁶ DOE PBSC GUIDE, *supra* note 159 at Chapter 5.5.N. Provisional fee payments are controversial and administratively burdensome on both parties because they must track the costs and payments. *See id.*

²²⁷ *See id.*

²²⁸ *See id.*

²²⁹ *See id.*

²³⁰ *See id.*

Government agencies are slow to embrace PBSC despite the potential cost savings.²³¹

With so much to consider in creating and molding an incentive-based PBSC, the government has an excuse. More care and planning must go into defining the performance-based statement of work on larger and more complex service contracts. Along with that statement of work comes a daunting task encompassing defining performance measurements and incentives. The Quality Assurance Plan will fall into place with this work done. However, this also shines a light on the Government since it must have a vey good cost estimating function and cost tracking function to actually administer the PBSC contract. Even with this daunting change of pace and culture, the performance rewards are impressive...they are worthwhile! One item remains, applying PBSC to managed health care systems contracts.

V. A Better Health Care Contract - Lessons Applied to Performance-Based Service Contracts for Managed Health Care

Man will occasionally stumble over the truth, but most of the time he will pick himself up and continue on.

Winston Churchill

The TRICARE contracts are multifaceted system service contracts requiring a huge range of services for both the health care beneficiaries and the Government. Under the first seven contracts awarded, between eleven and fourteen task areas exist for the contractor to address.²³² The TRICARE Management Activity (TMA) pared the list down to six discrete

²³¹ PBSC BEST PRACTICES GUIDE, *supra* note 100 at Chapter 2.

²³² REGION 3&4 AND REGION 2&5 CONTRACTS, *supra* note 66. The Region 3&4 contract segmented tasks into fourteen parts: Task I, Health Care Services; Task II, Contractor Responsibilities for Coordination and Interface with Lead Agents/MTFs; Task III, Health Care Providers – Organization, Operations, and Maintenance; Task IV, Enrollment and Beneficiary Services; Task V, Claims Processing; Task VI, Program Integrity; Task VII, Fiscal management and Controls; Task VIII, Management; Task IX, Support Services; Task

task areas.²³³ Acquisition reform and contract administration difficulties drove TMA to simplify the statements of work under an effort named TRICARE 3.0.²³⁴ DoD's health care acquisition reform effort proposes to overhaul TRICARE acquisitions by roughly following OFPP's PBSC effort.²³⁵ Do not expect drastic changes because the requirement remains substantially the same, but the Government allows the contractor wide performance discretion.²³⁶ TRICARE 3.0 is currently in the draft stage and has been for the last two years.²³⁷ The overall scope of work remains the same, as does the scheme for paying contractors.

Even though TRICARE 3.0 simplifies and reorganizes the requirements and gives the contractors more performance discretion, it still compensates the contractor through a Bid Price Adjustment provision.²³⁸ The DoD designed these Bid Price Adjustments to minimize

X, Automatic Data Processing; Task XI, Contingencies for Mobilization; Task XII, Start-Up and Transition; Task XIII, Resource Support; Task XIV, Foreign Claims Processing. *See id.*

²³³ TRICARE MANAGEMENT ACTIVITY, TRICARE 3.0, Draft Statement of Work, (visited November 4, 1998) <<http://www.ochampus.mil>> [hereinafter TRICARE 3.0]. The proposed draft consolidates tasks into six areas under the requirements portion of the statement of work: 1) Develop and Maintain Provider Networks; 2) Clinical Management; 3) Beneficiary Satisfaction and Services; 4) Claims Processing; 5) program Administration; and 6) Information Management/Information Technology. *See id.* The TRICARE 3.0 effort focuses the contractor on the basic work elements that must be performed, allowing the contractor significant discretion regarding how the work will be accomplished.

²³⁴ *See id.*

²³⁵ *See DoD HSRIV Historical Records, supra* note 17.

²³⁶ TRICARE 3.0, *supra* note 233.

²³⁷ *DoD HSRIV Historical Records, supra* note 17. TRICARE 3.0 started in the acquisition planning phase late in fiscal year 1996. *See id.* DoD Health Affairs sought input from the Lead Agents for the new performance work statement and volunteers to work on process action teams dedicated to redrafting the requirements into performance-based documents. *See id.*

²³⁸ *See REGION 3&4 CONTRACT AND REGION 2&5 CONTRACT, supra* note 66 at Section G

contractor risk on a potential six year contract for prices, beneficiary population changes and other trends that are beyond the contractor's control.²³⁹ How much of this is really beyond the contractor's control?

While health care is subject to economic variations like inflation and changes will occur in the military's direct health care system, contract modifications can address many of these changes. Health care related costs are manageable if the contractor has the ability to manage the beneficiaries. Contractors can exert more market and cost control with a large enrolled population. Arguably, the contractor controls costs and realizes profit when it enrolls beneficiaries in TRICARE Prime or encourages them to use the TRICARE Extra benefit. The contractor can affect the number of enrollees and system users through education, easy use, a wide provider selection and a robust supporting network. Managed care support contractors control costs by leveraging discounts and ensuring treatment is appropriate. A contract provision like the Bid Price Adjustment that relieves contractor risk for beneficiary health care potentially disincentivizes performance in other areas because the contractor always has a safety net.

Managed care support health services contracts focus two broad groups. Beneficiaries and health care providers comprise group one. The contractor and the Government make up group two. Beneficiaries are the ultimate reason for these managed care support contracts. Their effective and efficient care is the reason for the whole TRICARE effort. The beneficiaries' satisfaction will determine the ultimate success or failure of the program, since much of the benefit to the Government, the contractor and providers depends on the ability to

²³⁹ See *id.* at Section G-5a.(2).

manage their care. If there is no ability to manage the care because providers or beneficiaries will not participate, cost control and preventive care do not exist. One stumbling block occurs when providers will not participate in TRICARE. They refuse to participate when the system is difficult, unfair, clinically burdensome, or financially unprofitable.²⁴⁰ Since the beneficiaries cannot participate without network providers, this creates a vicious circle. The contractor must not only attract providers and groups into their networks, but must keep them in the program to develop a reliable network.

The Government's interest in incentives and placing the contractor at risk lies on several planes. The goal is simple. The contract must encourage the MCS contractor to address the difficult performance issues and reward them for succeeding. Since the providers and beneficiaries are responsible for spending the DoD health care budget, the Government benefits when the MCS contractors take more responsibility for contract performance. For example, a successful network allows enrollment, cost control and health care management by being available, responsive to the beneficiaries, and capable. When the Government removes contractor risk for these contract portions, the contractor does not succeed as envisioned. Besides, developing a network and enrolling a beneficiary population proved distinctly difficult in other contracts.²⁴¹ Nothing currently rewards the contractor when it

²⁴⁰ Congressman Joe Scarborough, Town Meeting on TRICARE (March 1997). During this town meeting, several doctors from the Pensacola, Florida area discussed their problems with the low reimbursement rates, slow claims payments and the problem with lack of continuity of care. *See id.* *See also DoD HSRIV Historical Records, supra* note 17.

²⁴¹ *DoD HSRIV Historical Records, supra* note 17. Humana Military Health Services, Inc. discovered network development difficulties early on in contract start-up. *See id.* After establishing networks in the Gulfport/Biloxi and Pensacola area, many providers dropped out because they did not receive timely payment. *See id.* Consequently, the beneficiaries could not remain enrolled in TRICARE Prime and the contractor lost the ability to manage that care. *See id.* The contractor lost credibility with both the beneficiary and provider communities which is significantly more difficult to regain. *See id.*

develops a robust network since the BPA compensates contractor through other mechanisms.²⁴²

Incentives must consider the competing interests at work in the TRICARE contracts. The foremost competing interest are those of cost control and quality health care services. Cost control in most minds, usually indicates limited or controlled services. Quality health care means getting Mayo Clinic-like attention. A second set of competing interests is the military system's need to sustain a wartime capability while integrating with the civilian managed health care system. Deployments and exercises drain military hospital capabilities and interfere the military's ability to work with the civilian network providers. The MCS contractor complains that the military cannot cooperate and be a contributing part of the overall health system since it has a different mission.²⁴³ Contractor interests also compete in quality, customer satisfaction and profit because quality usually requires additional expense which does not translate to profit. The contractor must make some reasonable profit to continue existing. Otherwise, it will fall by the wayside much as other unsuccessful businesses. Many valid competing interests exist as considerations in forming a workable PBSC incentive package.

A. Applying Incentives and Awards To TRICARE's Services

²⁴² REGION 3&4 CONTRACT AND REGION 2&5 CONTRACT, *supra* note 66 at Section G. When workload shifts from the network to the military hospital, the BPA adjusts contract price downward and shifts funds to the military hospital. *See id.* This is good only in the case where the military is more cost effective. If the network is or would have been a better financial deal, the Government ultimately loses because it bears the increased cost at the military facility.

²⁴³ *DoD HSRIV Historical Records*, *supra* note 17. Military hospital deployments force the MCS contractor to take on care the military would otherwise provide. *See Id.* This mission requirement precludes the military from status as a reliable health care partner. The contractor cannot depend on the military to handle referrals, laboratory tests or even primary care. *See Id.* Consequently, the contractor must factor inefficient redundancies into its network planning and development.

“In a time of drastic change it is the learners who inherit the future. The learned usually find themselves equipped to live in a world that no longer exists.”

-Eric Hoffer

Answering the question of whether PBSCs and incentives are appropriate and beneficial for TRICARE MCS contract, requires some analytical framework. The DOE describes such a framework in its Guide.²⁴⁴ Incentive analysis must begin with identifying the requirements through developing the performance based contract document.²⁴⁵ Once the Agency develops and defines the requirements, it must define the incentive structure.²⁴⁶ Defining and selecting requirements and considering and structuring incentives are the broad topic areas this thesis uses as a basis for analyzing the TRICARE work. Each area involves more than simply identifying work or establishing an incentive structure. The Agency must define work, prioritize and decide the key work elements subject to incentive. After defining requirements and selecting the incentive, the Agency must consider and structure the proposed incentive so a potential MCS contractor understands the goals adequately enough to make a proposal.

1. Defining The Work And Selecting Requirements For Incentives

The PBSC establishes the performance objectives and levels for the contractor.²⁴⁷ It clearly defines the performance objectives for the entire contract and the performance levels

²⁴⁴ DOE PBSC GUIDE, *supra*. Note 159, Section 2, Topic 2, Section 1.

²⁴⁵ *See id.*

²⁴⁶ *See id.*

²⁴⁷ DOE PBSC GUIDE, *supra* note 159, Section 2, Topic 2, Section 1.1.C. The performance work statement is the document that sets out the contract ground rules, determines responsibilities and risks. *See id.* Any confusion in the requirement’s objectives will cause contract administration difficulties and problems administering the incentives. *See also*, PBSC BEST PRACTICES GUIDE, *supra* note 100 at Chapter 2.

expected to successfully complete the work and earn the incentives.²⁴⁸ The DOE requires using a Performance Evaluation Measurement Plan (PEMP).²⁴⁹ A PEMP includes the requirements for administering the evaluations, the specific evaluation measures tied to the objective performance aspects, and the plan for evaluating subjective measures. An award or incentive fee evaluation plan also accomplishes the same goals. A well-defined performance work statement is a prerequisite, identifying the value of the contractor's work and the fee to which it is entitled.²⁵⁰

The prime incentive targets are those elements representing critical paths, requirements where innovation and excellence benefit the government and beneficiaries, and those requirements needing remedial attention from the contractor.²⁵¹ The Government conveys its priorities and desired performance levels through these fees and incentives.²⁵² These

²⁴⁸ DOE PBSC GUIDE, *supra* note 159, Section 2, Topic 2, Section 1.1.C.

²⁴⁹ *Id.*

In all circumstances, the applied categories of incentives are to be included in a Performance Evaluation Measurement Plan (PEMP), or similar document. The PEMP will usually be divided between an administrative section detailing the evaluation process and panels primarily associated with subjective incentives, a performance-based incentive section detailing objective performance incentives and an award fee section where subjectively evaluated incentives are grouped. In the latter case, the subjective incentive may describe in broad terms of the final outcome, or may be more specific by listing a number of sub-elements with specific outcomes which the contractor will strive to achieve. Broad subjective measures may also provide specific emphasis areas so as to provide the contractor with better instructions as to what is considered important. This provides the contractor with further guidance as to what specific areas relating to an objective will receive particular attention in the evaluation process. Careful consideration should be given to the wholesale incorporation of all elements of the PEMP into the contract. One should not incorporate those aspects of the PEMP which contain administrative information which may need to be revised from time to time and therefore requiring continuous modifications to incorporate those changes.

DOE PBSC GUIDE, *supra* note 159, Section 2, Topic 2, Section 1.1.C.

²⁵⁰ *See id.*

²⁵¹ DOE PBSC GUIDE, *supra* note 159, Section 2, Topic 2, Section 1.1.D.

²⁵² DOE PBSC GUIDE, *supra* note 159, Section 2, Topic 2, Section 1.1.B.

priorities are not always the same as the contractors. But it has a set of priorities reinforced with financial targets to help it focus on the work the Government finds important.

2. *Considering Impact and Structuring the Incentives.*

The DOE recommends addressing four considerations during developing appropriate incentives.²⁵³ This approach serves as an excellent guide for any complex PBSC, even for health care. The starting consideration depends on how well the Government defines the requirements.²⁵⁴ Clearly defined requirements allow more objective performance measures and incentives. Poorly defined requirements dictate subjective measures and incentives. Sometimes, requirements are clear and measurable, but measuring success is more subjective. When services do not fall neatly in either category, combining objective and subjective measures provides additional incentive options. For instance, provider and beneficiary satisfaction are subjective requirements since no established metric accurately captures the feeling of satisfaction. Claims payment, billing problems, telephone wait times and competent support are measurable elements also making up that satisfaction. Effective incentives for TRICARE contractors will likely combine both objective and subjective performance measures.

Secondly, the incentives need to contain three components: “(1) technical performance requirements (quality and quantity), (2) schedule (to be completed by when), and (3) estimated cost/actual costs at completion.”²⁵⁵ Technical and schedule components are self-

²⁵³ DOE PBSC GUIDE, *supra* note 159, Section 2, Topic 2, Section 1.1.D.

²⁵⁴ DOE PBSC GUIDE, *supra* note 159, at Section 2, Topic 2, Section 1.E.1

²⁵⁵ DOE PBSC GUIDE, *supra* note 159, at Section 2, Topic 2, Section 1.E.2.

explanatory and simply relate to compliance with contract terms. Cost estimation will clearly be the most difficult portion since it is an established Government weak point.²⁵⁶ In addition to cost estimating, the Government accounting system must be sufficient to track costs for the performance elements with incentives.²⁵⁷ The contractor should have a capable accounting system as well to ensure both parties are working with the same information. The Government's ability to relate performance costs to fee earned based on actual performance provides an invaluable baseline to measure contractor cost performance and valid justification to support fee payment or denial.²⁵⁸ The main caveat is that the parties must establish a sound cost accounting infrastructure.

The third consideration is the ability to monitor the contractor's progress and validate completion.²⁵⁹ This may entail incremental reviews at intervening performance points.²⁶⁰ This is intended as a progress check by any methodology deemed appropriate. These progress checks permit the Government the opportunity to award interim incentives if warranted. It also provides multiple opportunities for the contractor to determine how well it is doing during the performance period and allow the contractor to correct performance shortfalls. It may even allow the contractor another opportunity to earn the award or incentive it missed if the fee clauses are so structured. Effective monitoring tied to incentives can be a great motivational tool, prevent surprises, and allow timely correction.

²⁵⁶ TRICARE CHANGE ORDER PROBLEMS, *supra* note 22 at 9. The GAO criticized the TRICARE Management Activity for its inability to estimate budget costs; contract change orders costs; and the volume, frequency and types of changes to be made on the TRICARE contracts once awarded. *See id.*

²⁵⁷ DOE PBSC GUIDE, *supra* note 159, at Section 2, Topic 2, Section 1.E.2.

²⁵⁸ *See id.*

²⁵⁹ DOE PBSC GUIDE, *supra* note 159 at Section 2, Topic 2, Section 1.E.3.

The final consideration the DOE dictates is priority. The Government must consider and weigh related requirements to allow the contractor to place a given incentive in context.²⁶¹ The Government and the contractor may then identify any contingent performance measures, establish gateways, conditions for fee payment and incremental fee payment points. DOE discovered that incentives did not properly work when not tied to successful completion of other contract requirements.²⁶² The DOE found that the contractors focused maximum effort on obtaining the award or incentive while performing to a minimum acceptable level on the unincentivized contract parts.²⁶³ This would be counter productive particularly for an integrated health care delivery system since shortcomings are felt throughout the system. Tying the incentive to successful completion of the unincentivized contract elements establishes performance thresholds for the contractor to meet before being eligible for the money.

Considering these elements for each important incentive permit a wisely developed and justified incentive structure. Many of the managed care service contract requirements are not well defined and may require a more subjective approach. Some MCS contract requirements define the work in excruciating detail and allow little contractor discretion. Greater contractor performance discretion supported in PBSCs opens the door to better performance through innovation, flexibility, and ownership of the decisions and outcomes. Subjective

²⁶⁰ *See id.*

²⁶¹ DOE PBSC GUIDE, *supra* note 159 at Section 2, Topic 2, Section 1.E.4.

²⁶² DOE PBSC GUIDE, *supra* note 159 at Chapter 5.3.

²⁶³ *See id.*

measurement and evaluation coupled with a contractor's freedom to chose the performance approach are well suited to the TRICARE services.

Any data used to measure performance is suspect for several reasons. Information relating to CHAMPUS or civilian health care is often several years old after final claims adjudication and after the DoD approves the final numbers. Also, the military collected reams of data on military hospital operations, but service and installation specific guidance defines gathering this information. While this information and data is identified the same, it lacks system-wide consistency. The military health care system changed from an inpatient-oriented system to an outpatient and managed care system also beginning in the nineties. DoD's new health care system changes on a yearly basis due to downsizing, force restructuring, and implementing new managed care initiatives. Consequently, historical data does not paint an accurate picture of military health care system capabilities and does not allow many objective measures.

Contractors should develop, in conjunction with the Government, a new, meaningful data collection set that is amicable to performance measures. Enough differences exist to make the data unreliable for a meaningful performance measurement program. This makes objective performance measure less likely to work for many of DoD's managed health care program requirements until firm, consistent data is collected and analyzed. The success or failure will lie in the ability to identify fair subjective measures with which a contractor will agree.

B. Targeting and Applying Some Meaningful Incentives.

Unfortunately, the TRICARE MCS contracts are complex and span a broad range of services. This complexity does not lend itself to a neat set of simple incentives. DoD's TRICARE program is all about health care, and good outcomes, but is made of every other administrative task related to operating a business. Marketing, membership, payment, management, relationships, doctors and health care all create the managed care service. Every part of the contract needs attention for the whole effort to succeed in appearance and fact. Failure in marketing translates to lower enrollment and lower physician participation. Payment failures cause physicians to drop out of the network, costs to rise, and beneficiaries to disenroll. Each of the parts requires some performance excellence to avoid detracting from performance on other elements and overall performance.

One approach is to place one overall award or incentive on the contract. A single award or incentive fee may be a consideration, but it fails to capture the spectrum of different paths encompassing the military managed health care integrated delivery system. Such an approach lumps all work together in importance and does not clearly communicate any priorities regarding various elements of the work to the contractor. The contractor is consequently left to determine the performance areas it is willing to compromise to obtain its own acceptable cost-performance-profit levels. For any number of reasons, the performance areas the contractor views as important will be driven by cost and will probably be different than the Government high importance areas. There are elements of these contracts best defined and measured by compliance. In these areas, no amount of additional performance will benefit the Government, beneficiary or contractor. Some performance elements may require medical attention and may be candidates for individual incentives. Other areas may

warrant excellence beyond the basic performance parameters. To increase performance levels, incentives provide tangible financial rewards for performance success.

A small number of incentives, or none at all, equate to fewer Government contract administration requirements. Less administration usually translates to less oversight of the contractor. The stringent accounting requirements demanded by incentive contracts do not apply to the contractor accounting system. The Government personnel also do not need to be as sophisticated or skilled. In an era of Government downsizing, this is certainly an attractive option, particularly when the Government's internal resources are limited.

Conversely, a greater use of incentives requires additional contractor and Government resources to work with the higher cost accounting standards. The FAR and OFPP are clear in this regard since the Government must determine that the greater investment in resources and oversight must be worth the incentives.²⁶⁴ The more complex the incentive structure, the more difficult the administration. Consequently, the reward must be correspondingly high.

How complex should the incentive structure be? Before making that determination, consider the framework. These are seven contracts totaling \$15 Billion for over 8 Million beneficiaries covering 50 states. This is the first national managed care integrated delivery system. TRICARE is responsible for offering a triple option benefit for a mobile beneficiary population. The incentive structure should be adequate to cover the most important parts of the required performance. For a contract covering the expanse of services covered by TRICARE, the incentive schedule will not be simple.

²⁶⁴ See PBSC BEST PRACTICES GUIDE, *supra* note 100 at Chapter 1.

Health care is not a “minimum requirement” type of activity. No recipient wants “adequate” care, they want positive outcomes, the best care they can afford, and a high degree of competence and professionalism. To the extent the Government is able to incentivize the best health care, innovation, cost control and smooth program management, the beneficiary, the Government and the health care system will clearly benefit.

C. The Health Care System.

The overall purpose of the MCS contracts is to supplement a military medical system that is tasked to prepare for war, maintain the health of its soldiers, sailors and airmen, and care for those who served and retired along with their families wherever they may live.²⁶⁵ This requires a health system that blankets the United States. The direct care system supported by the military cannot accomplish this task alone. CHAMPUS was created to fill the gap,²⁶⁶ but it does not have the ability to control the costs since it is really an insurance indemnity health program. Managed health care provides the current means of developing an expansive national health program for the military and its beneficiaries.²⁶⁷

This health system is designed to provide health care to beneficiaries in the direct and indirect health system. This requires the interaction of a lot of different elements. The contractor must establish and maintain provider networks, provide some oversight of the care provided, enroll and maintain beneficiary health care, process claims, manage the health system to include the interaction with the military direct care facilities and provide

²⁶⁵ MHS STRATEGIC PLAN, *supra*. Note 9.

²⁶⁶ The Dependents’ Medical Care Act of 1956, P.L. 84-569.

²⁶⁷ National Defense Authorization Act of 1994 § 731.

information systems that are the backbone of any managed care system. These are the broad work areas requiring the contractors' attentions.

Effective incentives first require reasonably identified services, performance goals, and expectations. The Government must determine the appropriate incentives or fees after defining the services, goals and expectations.

D. The Requirements.

1. Provider Networks:

a. Defining The Services And the Critical Tasks

Adequate provider networks represent the bedrock of the military managed health care system from the beneficiary's perspective.²⁶⁸ The provider base is also one of the cornerstones of any integrated delivery managed health care system.²⁶⁹ A committed, educated and robust provider base is important because the doctors must manage the beneficiaries' care within the plan's benefit constraints. They must also manage the costs to ensure the care delivered is necessary and cost effective. Primary care providers must plan health care delivery in concert with the managed care organization to ensure seamless coverage by competent network specialists when specialty care is required. The entire provider network supplies important follow-up and long term preventive care. Primary care

²⁶⁸ See DoD HSRIV Historical Records, *supra* note 17. In Regions 3 and 4, the Government found that a poorly developed network limited enrollment in TRICARE Prime, caused beneficiary satisfaction to plummet and limited health care delivery's effectiveness for that particular area. See *id.*

²⁶⁹ See Peter R. Kongstvedt and David W. Plocher, *Integrated Health Care Delivery Systems*, in ESSENTIALS, *supra* note 54 at 35.

providers and specialists participating in a managed health care plan generally agree to care for a select number of beneficiaries, giving the plan a cut rate for services. Sometimes these primary care providers are paid a specific amount of money per member per month. This is known as a capitated fee schedule and the primary care provider is at risk for those individuals' care. It is crucial to have a sound, cooperative and educated network to have any hope of being cost effective and not saddling some providers with high costs.

The Government is concerned with a number of different issues in any provider network. Most of all, the Government needs the contractor to establish the minimum network throughout the required areas. Once the network is established, the next issue is whether the MCS contractor can maintain those providers in the network. The contractor must consider the administrative needs to educate, support, oversee and pay these participating providers.

The government also desires having a contractor establish additional networks where cost effective. Larger, robust networks allow the contractor to manage care for more beneficiaries impacting the cost of care. As a method of assuring quality, all of the networks must also be accredited by an oversight function. This is the doctor end of the network. It is also health care's frontline for beneficiaries since their exposure at this point colors their perception of the care delivered and molds their understanding of the system and their own health. It will be key for the contractor to ensure the network can provide timely access to care from the beneficiary's perspective and supply a provider workforce that knows that beneficiary's available benefit. A final unique aspect of this health system is the network's interaction with the direct care system. For locations with military treatment facilities the contractor network must interact with and supplement the military direct care system. Referrals for specialty care are designed to flow and utilize the available resources from both systems.

Care can only be successfully facilitated where each system communicates and promptly shares patient information.

To establish an HMO, there must be some network of providers, and the contract will establish the minimum requirement. The contractor will undoubtedly comply with the minimum requirements. That is not what the Government is really after. It is incumbent on the government to ensure network success by identifying the key network aspects and providing a focused incentive to excel. Network adequacy is probably one of the most visible parts of the contract aside from the beneficiary claims bills and overall cost since it is the part the beneficiaries must use. Without an adequate network of primary care managers and specialists, there ends up being a host of problems surrounding getting care and payments. Once the network is established the work begins anew because it requires “care and feeding.” The providers must receive benefit and process education, they require frequent contractor support, quality assurance oversight, and timely correct payment is crucial. These are key aspects the Government must survey and ensure to provide the underlying basis for network success.

A couple of threshold requirements that simply require compliance are network accreditation and delivering network reports. Accreditation is simply a stamp of approval by an oversight organization similar to the Joint Commission for the Accreditation of Health Organizations (JCAHO). This is important because the accrediting organization ensures systems, processes, people and training are established to support the network’s operation. The MCS contractor must simply be accredited, no amount of additional effort will benefit the Government through “better” accreditation. Network reports will simply provide number and ratios to the Government as a quality assurance oversight tool. The contractor must

submit these reports accurately and on time. Compliance is the only meaningful measure.

There is little here that provides the opportunity to excel and any additional effort would derive no benefit for the Government. Beyond simply addressing the network, the users also reflect on the network's success.

Beneficiary access to health care as well as network interaction with the direct care system are other indicators of success. Access to care partially reflects the health and robustness of the network. Poor access demonstrates network inadequacy and other problems. Access problems arising from distance, inadequate network development, or lack of provider cooperation all present political flashpoints, increased cost risks, and potential network maintenance problems. These problems impact beneficiary confidence in TRICARE. The contractor must also work with another part of the system.

The contractor's ability to facilitate network integration with the existing military direct care system is crucial. A working relationship supporting a free flow of information between the network and the military hospitals is critical to managing beneficiary care. It is also critical to capitalizing on the most cost-effective elements of both systems. If these two system entities do not coordinate and communicate, the health care provided is for naught. This will result in costly and repetitive care and instill a system-wide distrust. Records, consultations and appointment, procedures must be shared and run smoothly. This communication issue is very important.

A network is almost a living organism requiring frequent attention and more than just basic performance to truly succeed. The preceding identifies several potential areas in the network where excellence and attention return significant benefits and dividends. These are

the areas suitable for incentives and the additional Government resources required to administer the appropriate incentives.

b. Considerations and Structures

Provider networks are key to the Government's HMO. TRICARE requires the contractor to do two main tasks in this regard: develop an adequate network and maintain that network. Under each of these tasks are many other requirements. Most of the network goals and requirements are of the nature that the Government can identify what performance is acceptable. But, no fixed numbers describe adequacy or success, making this task area a subjective incentive target.

Items like meeting access standards, licensing, regulatory compliance, credentialing, reporting, current provider lists, and network accreditation are strict compliance items. The Government would receive little to no benefit by contractors trying to exceed the baseline performance levels and there are no quality, schedule or cost considerations. These and similar functions are not worth incentivizing, but making their delivery or performance a gateway requirement for incentive eligibility is a consideration.

The Government does benefit by the contractor enhancing key network elements like timely network development, the content of primary care managers and specialists, cost controls and payment, education, and interaction with the direct care system. These functions relate to quality, cost and schedule considerations. Once the contractor develops the health care network, it must maintain, educate, and support that organization. Anything a contractor does to enhance these network elements, benefit the Government and the beneficiaries.

Timely network development represents the contractor's ability to deliver health care on the contract start date. The incentive focus on the contract's health care delivery date. If the contractor delivers an operational health care network in all the required locations, it should receive an incentive. To date, no contractor has delivered a fully operational provider network on the health care delivery start date.²⁷⁰ Non-operational network is a public relations nightmare since it destroys beneficiary and provider faith in the system, slows enrollment, and delays potential managed care cost savings. If the contractor avoids this public relations problem, the Government should consider an incentive for implementing a provider network on time.

The Government cannot define an adequate network by any other benchmark than the contractor meeting demand for care. Developing an adequate network for the beneficiaries means having an adequate number of primary care managers, credentialed and educated to meet the first enrollment numbers. An adequate network also means having specialists available for referred care. Are there any numbers or statistics defining this adequacy? Are there any other ways of defining this adequacy?

The answer to the first question is that there are no specific ratios of providers to beneficiaries. Much depends on the individual providers participating in the network, their workload and capabilities. During competition, the contractor will propose enrollment ratios and the Government will evaluate those ratios for realism. The Government can ensure the contractor meets, or even exceeds, its own projections as one form of objective measurement. However, the contractor's meeting those ratio goals does not capture whether the network

²⁷⁰ See *DoD HSRIV Historical Records*, *supra* note 17. Each of the seven TRICARE contracts started with significant difficulties, but matured into functional contracts. *See id.*

really works. The Government can only determine success by the enrolled beneficiaries' ability to obtain health care. The contractor is successful if the beneficiary obtains appointments, referrals to network specialists, and has no billing problems. Failure shows up with beneficiary and provider complaints about the system and with payment and claims problems diminishing the health care experience. These are hardly measurable indicators and support using subjective incentives.

Once the contractor develops the network, success becomes a maintenance question. Contractor efforts in provider education, support, quality management oversight, payment and demonstrated financial savings become success indicators. Provider education, support, and quality management are a question of effectiveness. First, the contractor must offer these services, then the providers can give feedback. Usage levels might also provide a measure of effectiveness. Claims payment problems indicate the contractor's education and support effectiveness. Many errors are from improperly completed forms and a failure to understand the TRICARE program.²⁷¹ Reductions in the overall cost of civilian health care might also indicate that the contractor's network is effective. These performance areas provide an overall subjective picture of the contractor's network development and maintenance success.

This is an area where the contractor can have some valid objective incentives, but mostly have subjective incentives. Practically, a totally objective incentive structure would provide the Government little flexibility and possibly hinder the Government's network goals. The contractor could meet the established provider to beneficiary ratios, yet have the network be

²⁷¹ See DoD HSRIV Historical Records, *supra* note 17. Lead Agents found that MCS contractor support disappeared after the providers signed contracts with the prime contractor. *See id.* The telephone support regarding benefit questions was ineffective and several contractors failed to deliver printed guidelines. *See id.* This drove the network providers mad and created significant misunderstandings. *See id.*

ineffective. A totally subjective fee might frustrate the contractor if the Government was never totally satisfied. A compromise using a hybrid incentive fee structure is a viable solution. In this case, the Government and contractor can agree on the network size and mix, establishing some fixed numbers the contractor can meet. Exceeding the base line ratios will entitle it to a small percentage of the fee in this area. A subjective incentive linked to beneficiary and participating provider satisfaction and the contractor's success in maintaining a robust network are realistic indicators and evaluation factors. Objective incentives fail to adequately describe network success. Moreover, they do not allow for a subjective look at the actual success in terms of satisfaction with the product the contractor produced.

Next, the Government must consider whether it is efficient to incentivize all the different network elements or focus on a larger incentive for overall network success. Five other functional areas remain in this analysis. More incentives dictate a more complex contract administration burden on the Government and contractor. Too much complexity will frustrate both parties and probably cause disagreement.

Government surveillance is critical to verifying the contractor's success in this area. The contract administrators must judge the contractor largely from its data and from and from anecdotal evidence gathered through reports, complaints and surveys. A fee determining official should have latitude to consider the overall picture and the PEMP to support that evaluation. Any contractor effort that creates an efficient and user-friendly network is worth an incentive.

2. Clinical Management.

a. Defining The Services And the Critical Tasks

Clinical management involves two basic parts in the TRICARE arena. One clinical management element focuses on monitoring and managing the beneficiary population's health. The remaining element captures and attempts to manage provider behavior through conducting utilization and quality management (UM/QM) across the health care system's spectrum. Clinical management may not appear complex on the surface, and may actually seem a hindrance to health care delivery. Many problems, such as the *Wilson v. Blue Cross of Southern California* and *Wickline v. California* cases, arise due to the restrictions forced on the provider's discretion and the beneficiaries by the Clinical Management and UM/QM processes. Folded into this overall clinical management process are case management functions and appeals. Ultimately, this is the area that attracts public attention as the "fiendish" part of managed care denying arguably needed health care.

Managing beneficiary health care in the context of the immediate discussion represents a process of; determining a population's health status; educating that population about regular health screenings and healthy lifestyles; and, using the data collected to focus health care resources where appropriate.²⁷² The network providers and the managed care organization have access to its beneficiaries through the basic enrollment processes and the primary care network. At these access points, the MCO can screen and collect key information allowing for better health care. The organization also has the opportunity to educate the beneficiary regarding health lifestyles, health assessments and long term management. These functions are important because the organization can identify enrollees with special needs or target them as opportunities for improvements. The system also has a unique opportunity to educate the beneficiaries regarding self care and long term management that will allow a

²⁷² See REGION 3&4 AND REGION 2&5 CONTRACTS, *supra* note 66.

better focus on true problems as opposed to addressing unimportant issues, utilizing expensive resources. Finally, this data and education allows the MCO to allocate resources against more pressing health problems and more appropriately focus specialists needed to educate and manage the beneficiaries. In this way, the health care system can positively impact its enrolled population through preventive health care methods.

The next part of clinical management represents the process of overseeing the providers ensuring the care is both appropriate and high quality. The contractor must establish and implement an acceptable UM/QM program not only to meet the contract requirements but establish the seminal health care oversight mechanism for any managed care program. A UM/QM program is responsible for managing the delivery of health care, reviewing that delivery of health care for appropriateness and effectiveness, for authorizing specialty health care services, tracking provider usage and behavior and conducting case management.

Getting into the providers' traditional business by monitoring care, questioning decisions, and planning for beneficiary care creates tremendous friction. In many cases, it places oversight at odds with unrestricted physician discretion and the beneficiaries' perception of adequate care since they do not get what "the doctor ordered". However, this oversight holds the providers accountable to justify treatment and forces them to consider their selected course of care. It burdens provider discretion with the awareness of guidelines and established standards of care.

UM helps managed health care delivery, focusing on the beneficiary receiving the right treatment at the right time in the right way. The providers must consult UM/QM personnel to ensure care is authorized and appropriate. As a part of this function, the UM personnel are

sometimes required to authorize care and continued treatment. This is key to the government to ensure the benefit is appropriate and needed, as opposed to frivolous. It also serves to ensure the beneficiary does not get billed for care outside the health plan benefit.

UM/QM also comprises the “heinous” function of retrospectively reviewing care to ensure the care was effective and the provider’s decisions appropriate. This allows the opportunity to identify problem areas, ensure quality, and modify physician behavior. Statistically tracking provider behavior permits identifying problem providers and beneficiaries. The contractor can educate the providers and ensure the beneficiary receives care and counseling as needed. This profiling facilitates sound resource management and ideally saves money for all concerned. Case management part of UM/QM helps plan the longer term or more involved care. Typically the case managers develop a treatment plan for the beneficiaries’ and doctors’ benefit. It focuses on recovery and long term care while ensuring the right assets are used. Case management can provide benefits at several levels. It establishes goals for the patient, giving realistic expectation and showing that there is a plan to treat and follow for their care. It allows for placing the needed assets against the care and managing recovery from a medical perspective. This planning also allows cost allocation and management as needed. All of these functions are key to managing health care delivery whether on an inpatient or outpatient basis. The Government benefits when the UM/QM program is a part of the provider team – an asset. It also benefits when the process runs smoothly and care is not denied inappropriately. UM in the network is invaluable, and more so when it runs well.

The contractor is primarily responsible for beneficiaries enrolled to its network, but also has a responsibility to conduct UM/QM oversight for care provided in the direct care system.

This review is key to ensuring system-wide consistency in oversight and quality care. It allows comparing each system to better identify significant deviations and areas needing additional attention. The MCS contractor will need to educate and integrate with military hospital management to ensure the systems dovetail. Not only is this important for numbers purposes, but it is important because the beneficiaries must believe in the system and see they are measured against the same criteria. The providers must also believe that each part of the system is pulling its load. This review process also ensures that the contractor is responsible for authorized care whether or not it is later determined inappropriate to prevent the beneficiary or the military from paying unjustified or improper bills. Finally, as a part of the UM/QM process, the contractor must implement an appeals and grievance process allowing the beneficiary the opportunity to contest situations where care is denied. This is important to the beneficiaries, providers and Government to ensure checks and balances are available in the event of disagreement. It is very important that this system be fair and timely. Health care always has an element of immediacy about it and a slow grievance process may well equal denying needed or appropriate care. The overriding need is for this system to facilitate resolving disputes over care while not standing in the way of necessary care.

UM/QM forms an umbrella over the entire managed care organization and is used to monitor compliance with rules and care guidelines, track cost effectiveness, ensure quality care, gather encounter and outcome data and focus needed education efforts. An effective UM/QM system ensures provider and beneficiary compliance with the managed care organization's rules by mandating guidelines and comparing provider outcomes using peer pressure. It also ensures the right care is delivered in the right place at the right time. It also helps apportion responsibility for problems and successes by focusing resources where most

needed. UM/QM provides a needed managed care oversight role that characterizes managed care organizations. Excellence in the UM/QM arena will translate to a better, more responsive health care program and benefit. Incentivizing some of the elements to exceed minimum requirements will help the managed care organization run better, characterize the overall system in a better light for both providers and beneficiaries, and foster innovation encouraging improvements.

b. Considerations and Structures

Clinical Management has two basic purposes. One is to oversee the beneficiaries' health care delivery and management. The second is to oversee the health care provider's operations. Both purposes have objective elements in the reviews conducted, the recovery plans developed or the beneficiaries contacted, but numbers do not describe the program's success. Operational efficiency is the key performance factor valued in this function. The main contractor functions are the ability to collect data, manage long term care, review and authorize care, conduct appeals and grievances, and monitor the military hospital system. Accurate objective measures simply do not exist for this portion of the managed care support contractor's work. Is the work worth incentives? Will the Government benefit through performance excellence?

Clinical management is one of the areas the MCS contractors usually perform competently and follow established guidelines. This is also one managed care function coming under increasing state regulation because of its reputation for making inappropriate medical decisions regarding care. Most managed care companies invest significant effort and money into this program because it provides data on the health plan's effectiveness and

because it is concerned with the potential for further regulation.²⁷³ Utilization management is a function where most managed care organizations feel restricted by the cumbersome requirements defined by the current TRICARE contracts.²⁷⁴ The notable only improvements of interest to the DoD would be those improving cost and effectiveness. Allowing the contractor to implement industry standard clinical management programs will benefit the contractor and the Government.

The Government may realize some benefit by incentivizing contractor performance in this arena, but the impact is negligible. The contractor likely has the expertise readily available, and must collect the data generated by operation of the clinical management program to evaluate its own performance. Increased beneficiary or provider monitoring and additional pre authorization reviews may not produce greater returns or savings. Gathering information on the direct care system's operations or running a faster appeals and grievance program will produce minimal additional Government benefit. Since clinical management is not a problem, it runs well and the very nature of the managed health care system dictates it be done well and according to established industry rules, a minimal incentive may benefit the overall program. Clinical management incentives should focus on maintaining a sound program. If the contractor operates clinical management tasks over the course of the year with no mistakes and no adverse public exposure by providers or beneficiaries, it should receive some incentive for effectiveness. Any glitches in the system should minimize the

²⁷³ See *DoD HSRIV Historical Records*, *supra* note 17.

²⁷⁴ *See id.* Humana Military Healthcare Services and TriWest Health Alliance aggressively pursued proposals to change DoD's antiquated UM/QM oversight. *See id.* Each company sought to implement the industry standard oversight, data gathering, and review programs. *See id.* These changes did not occur despite projected cost benefits and efficiency improvements. *See id.*

incentive received. A subjective incentive structure based on descriptive rating²⁷⁵ is appropriate. The Government can monitor this program's effectiveness with minimal manpower, using data, complaints, and the media.

3. Beneficiary Satisfaction.

a. Defining The Services And the Critical Tasks

Beneficiary satisfaction and the services the MCS contractor provides represent another cornerstone of the managed care organization. Without a robust patient enrollment base, the organization has no clientele and consequently has no basic, reliable income. If beneficiaries are unhappy, they disenroll, removing the opportunity to manage their health care. Then the opportunity to control costs is gone. Ultimately, this is where the organization succeeds or fails because the beneficiaries vote with their feet. The question becomes how does the Government enhance beneficiary satisfaction with the managed care system?

Beneficiaries in TRICARE interact with the system in three main ways: they visit the providers for health care and health questions; they access the contractor for information, advice, feedback, benefit questions, and they pay bills and receive claims processing feedback. A failure in any one of these parts represents a failure of the system. The beneficiaries lose faith in the health care system's ability to provide needed services and even its ability to function competently.

Many of the beneficiaries enroll because they are told it is a financial good deal. It is ... generally. However, once enrolled, the beneficiaries cannot help but feel kind of "captured".

²⁷⁵ For example, a descriptive rating is poor, fair, good, very good and excellent.

Each enrolled beneficiary is at the MCS contractor's mercy for two reasons. The beneficiaries' choices are limited to providers participating in the plan and other approved providers, and it is responsible for setting up a network responsive to the enrollees' varied health care needs. If the network is not developed or is inadequate in any other manner, the beneficiary ends up paying for care beyond the stated cost share. Not only does the beneficiary pay financially, but he also pays in time and frustration.

Managed care limitations are new to DoD beneficiaries. The system choice limitations and low, but yearly enrollment payments for retirees are also new. This newness dictates that the beneficiaries be educated on using the TRICARE managed care system and educated using a realistic set of expectations. It also requires that the educators be competent and versed in the entire TRICARE system. Every TRICARE contract start-up is and was accompanied by difficulties impacting beneficiary satisfaction. Much of the initial disillusionment arose due to the extremely short implementation periods dictated by DoD Health Affairs.²⁷⁶ The military had little ability to train its own educators and providers and the MCS Contractors hired individuals and tasked them to immediately begin teaching.²⁷⁷ The teachers did not understand the program adequately to competently answer all questions and provide guidance. The secondary educational front was phone access to the Health Care Finders²⁷⁸ and other contractor personnel. Beneficiaries often encountered busy phone lines or personnel unable to answer questions at the outset. Providers were unable to obtain

²⁷⁶ See TRICARE Contracts *supra* note 66 at Section B.

²⁷⁷ See DoD HSRIV Historical Records, *supra* note 17. The contract start-up was so rapid that the contractor did not have time to hire, train the personnel, and implement the remainder of the contract; consequently, competent briefers and educators were not before the beneficiaries for their first exposure to TRICARE. See *id.*

benefit guidance, procedure and referral approvals, and claims filing support from the contractor. Beneficiaries and providers complained to each other about the system, so both parties grew dissatisfied. A better interface for the beneficiaries and provider coupled with competent education is a start. If the beneficiaries understand how to use TRICARE, they will be confident and their satisfaction will rise.

The contractor billing system, as with most health care systems, sends out a mind-numbing array of bills and explanations for every encounter. The providers also send out additional statements to the beneficiaries with billing amounts exceeding the allowable payment under TRICARE. Most of the time this is simply confusing, when things go awry it is maddeningly frustrating. These billing episodes, particularly for inpatient care, may take from six months to a year to resolve. Unfortunately, the beneficiary is often in the middle of the billing dispute and suffers the emotional whipsaw of the bill collection process. Billing quandaries and lengthy claims episodes drive beneficiaries from the managed care option simply due to the hassle.

A key indicator of beneficiary satisfaction is enrollment. The contractor's ability to garner and maintain robust enrollment in the managed care plan is clear evidence of success. Education and marketing are fundamental to the TRICARE program and cannot be overemphasized in relation to enrollment and satisfaction. Education and marketing reaches out to the beneficiary, provides access to the program, tells how it should work, and develops

²⁷⁸ See TRICARE Contracts *supra* note 66 at Section C-2. A Health Care Finder is the contractor's first line of access. They are required to arrange appointments, answer benefit questions, work with initial complaints and provide other limited guidance.

realistic expectations. This also applies to the network providers. When the beneficiaries understand how the system works, know what to expect and know how to look after their needs, they tend to be happier. They also are more patient with system problems. If the contractor can keep them enrolled, that partly confirms the quality of their services. If the network has to grow to accommodate more enrollees, reputation is clearly good and the program is a greater success.

Any point of service that enhances a beneficiary's experience with the contractor, provides more access and allows communication is a definite plus. Any convenience the contractor provides, such as payment options, simplified claims and billing, and easy access establishes higher levels of satisfaction and confidence. These aspects of the managed care system are worth enhancing and incentivizing. The interface with the beneficiary is key to TRICARE.

b. Considerations and Structures

From any point of view, beneficiary satisfaction and services are the most important part of this system. The beneficiary is the customer. Anything the contractor can do that boosts and maintains enrollment in TRICARE Prime ultimately benefits the Government through cost savings and health care management. Beneficiary satisfaction is measurable primarily by enrollment. The contractor's failure to accomplish some key tasks requiring beneficiary interaction can directly impact enrollment and customer satisfaction.

Enrollment in TRICARE Prime is a definitive number. The Government can establish a firm target for beneficiary enrollment. The contractor usually can prove beneficiary satisfaction when it meets the established enrollment goal, exceeds it or falls below it. As it

meets those goals, the Government can objectively apply incentives, encouraging the contractor to seek more enrollees while maintaining enrollment with the existing population. While enrollment provides a good measure, other aspects of the contractor's requirement affect beneficiary satisfaction.

Beneficiaries regularly use the contractor's administrative support system. Telephone access, contractor support, and briefing or education sessions are the primary means through which the beneficiary accesses the contractor. Beneficiaries call the contractor for support in determining benefit questions, arranging for appointments and with minor health questions. In every case, it is a plus to talk with a live person, not being put on hold or talking with an employee who does not know the TRICARE program benefit. If incentives can encourage the contractor to invest more in knowledgeable personnel to answer the telephone and questions, that alone would raise beneficiary satisfaction in the health care system. A hybrid incentive will likely work to the Government's benefit. The objective parts of the incentive can measure how long it takes to talk with a person while the subjective measures can evaluate whether the contractor personnel are knowledgeable and courteous. Similar evaluation factors can apply to educational briefings. The Government can gather input through surveys, recorded wait times and simple surveillance.

An accurate contractor billing system is also crucial. Incorrect bills or ones with little to no explanation cause significant emotional distress. After receiving several bills, the beneficiary will begin to wonder whether there is a real benefit to TRICARE Prime, and whether the hassle is worth the money. Better beneficiary relations are worth some incentive, since the beneficiary is the ultimate customer in the TRICARE contract, incentives promoting greater interest in the beneficiary, courtesy to them, and greater knowledge in the

contractor personnel working with the beneficiary. They can include both subjective and objective measures.

The DoD should incentivize beneficiary satisfaction with an overall subjective award fee based on the elements of education efforts, support, access to care and enrollment, and billing problems. TRICARE contractors must conduct education programs to market and to educate beneficiaries. The contractor must provide effective support regarding questions and healthcare issues. The contractor must satisfy the beneficiary with reasonable access to all primary and specialty care to keep them enrolled and encourage further enrollment. Finally, contractors must get the bills right. Each of these areas is important and the Government should allow the contractor to establish some minimum performance levels. For instance, it should establish the number of education sessions, telephone wait times, and number of billing problems that are the baseline. If the contractor meets that baseline, it ensures a minimum fee for that work. Then place an overall award fee for excellence on beneficiary satisfaction. A yearly beneficiary survey can help determine the fee. In this way, the DoD can encourage performance excellence with regard to the beneficiaries. This does not require much effort other than using statistical reports, beneficiary surveys and media reports for Congressional complaints.

4. *Claims Processing.*

a. *Defining The Services And the Critical Tasks*

Claims processing represents the money – the financial bottom line and is another keystone managed care function.²⁷⁹ Payment disruptions, whether the result of the providers or beneficiary's mistake, cause significant problems and ultimately represent a contractor failure at some point in the process. Claims problems are the culmination of several layers of issues that build on each other. A dearth of effective provider education related to understanding and administering the health plan benefit along with understanding the MCS contractor procedures often significantly contributes to claims problems. It is unfair to lay all fault with education or to expect it is the salvation. Providers and staffs also need MCS contractor support through telephone access, published and updated guidelines and approved provider and procedure referral lists. This is potentially one of the simplest areas in the contract to incentivize because the metrics are relatively easy to establish and risks are easy to allocate. The underlying reasons for claims complications are more difficult to pinpoint. However, the ability to make it work lies with timely payment, education and support.

Payment issues are important because they reflect a provider's continuing financial vitality. They also reflect a claims process that fails at some point. Claims issues are certainly fixable and are rules within the TRICARE contractor's control. Non-payment, regardless of cause, creates ill will and alienates the beneficiary and provider community the health plan serves. The providers and staff always talk with their patients about problems and overall dissatisfaction. The patients pick up this attitude and become as unhappy as the providers. Late payments are effectively the same as non-payments because they interrupt cash flow and ultimately increase the provider's administrative burden. When the claims

²⁷⁹ See DoD HSRIV Historical Records, *supra* note 17. The contractor network in the Florida Panhandle fell apart twice because the subcontractor processing claims failed to pay on time. *See id.* This left the enrolled beneficiaries temporarily without health care coverage. *See id.*

process is dysfunctional, the providers leave the network, which further sullies the managed care plan's reputation. Consequently, new providers and beneficiaries are reluctant to participate and are more likely to drop out at the first sign of problems. This is preventable.

To the extent that the contractor receives claims with errors, it must seek alternative resolutions avoiding outright denial. MCS contractors must intercede, collect the correct information if possible. This will prevent an annoying and lengthy resubmission process burdening the network providers. The MCS contractor should implement policies requiring contacting the provider or staff for claims corrections, obtaining rapid review, and quick reconsideration. Then as it corrects problems, the contractor can work with providers, focus education efforts and ensure the cash flow needed to support the network. During claims processing and interaction with the providers, it should be possible to reduce errors, make corrections and educate the providers and staff. Knowledge through education offers the best avenue to make the claims system work.

Often provider and office staff are not adequately educated regarding the claims process and its attendant parts. Often the providers and staff do not pay any attention to the education offered. This is a difficult audience to work with on the best days. Providers resent the limitations managed care places on their practice and are apt to disregard the plan's guidance and rules even though they agree to participate and sign contracts.

DoD's TRICARE program covers a wide range of health care services, but has limitations like any other plan. Providers and staffs must know these procedure and treatment limitations to ensure they do not perform or refer beneficiaries out for unauthorized services. Knowing the limits also permits the providers to advocate for justified coverage

exceptions while explaining the managed care plan limitations to the beneficiary. The provider then becomes a plan advocate and health care gatekeeper along with being educated regarding the claims payment process.

In a health program as complex as TRICARE and as regulation driven as both managed health care and government contracts, education is clearly required. The form is not as important as getting the message across. MCS contractors must develop and implement education plans that continue over the contract's life. These efforts need to focus on the health plan benefit as reflected in the claims process to ensure appropriate and timely payment. The MCS contractors also must use the claims process to gather information, focus education, and intercede to prevent problems arising. While providers may be educated, more education is usually required.

MCS contractor must support its network of providers and staff to ensure the claims process runs as smoothly as possible. Published plan guidelines approved referral listings and telephone support are active measures supporting daily operations. In Region 2, the MCS contractor did not publish guidelines, provider handbooks, and referral listings supporting daily health care operations at the outset of the contract.²⁸⁰ After that information was published, it was not updated. This left the network provider without a support base other than calling the MCS contractor for guidance. This did not turn out to be a good option particularly in the early stages of contract implementation. MCS contractor support staff was not thoroughly trained at the contract's initiation regarding the benefit, referral process,

²⁸⁰ Discussion with the TRICARE Prime Network provider, Dr. William Streiker, PromptCare, July 10, 1998.

referral authorization and claims process. The MCS contractor was unable to support provider questions. Consequently, the providers lost faith in the contractor's competence.

Not only were the program guidelines not published, network specialty referral plan not established, but the contractor individuals designated to answer questions were incapable of effective support. No effective failsafe was established to competently fill in for the lack of written guidance. The network providers had no reliable support mechanism to prevent problems before they matured to crises.

While tracking and correcting claims, educating providers and supporting network providers appears to be a fairly simple undertaking, it has borne out otherwise. Under the current MCS contracts, claims issues seem to be one of the most significant problem areas for providers and beneficiaries. There is a huge amount of good will and efficiency to gained by a sound claims process from top to bottom. Ensuring a smooth money flow is crucial to managed care success. This is an area easy to follow with metrics and deliverable events or goods, and consequently ripe for incentives.

b. Considerations and Structures

Claims issues result from non-payment or untimely payment and poor or incomplete contractor education of the providers and staff. The mistakes the provider makes usually result from the contractor's lack of educational or administrative support. Sometimes, the providers do not listen, but most problems in the early stages of contract performance arise due to the provider not understanding some part of the TRICARE program. If the Government can incentivize better support by phone and in person, many problems would evaporate.

Quantity, timeliness, and processing expense define the contractor's baseline performance levels. The contract requires the MCS contractor to process claims within a specified timeframe, be capable of processing a certain number a month and the Government evaluates the claims processor based on how much it costs to process a single claim. This is one of the few contract requirements that is almost solely metric driven. The contract establishes the performance standards, and the contractor meets them. The contractor controls most of the claims processing variables by controlling the computer systems and the number of personnel working the claims. Objective performance evaluations clearly apply to this task.

The providers add an element that requires some additional attention possibly with subjective incentives. When providers improperly complete claims forms and the contractor denies the claim, it causes the providers and contractor problems since they must repeat the paperwork to resubmit and reprocess the claim. Additional education efforts and contractor support preventing claims problems avoids network provider anger with the contractor and ensures a network exists for the beneficiaries. Providing a subjective incentive to encourage provider education and support may help promote payments and prevent the disgruntled providers from sending bills to the beneficiary. When contractor pays the provider on a regular basis, many other issues are overlooked and contract administration is simpler.

The contractor in many cases does not provide adequate technical support by phone or reference manuals reflecting billing policies. The DoD can monitor education by the number of sessions and the availability of telephone and updated documentary support. The DoD can also survey the network providers regarding their satisfaction with the plan. Claims errors and payment timeliness also are critical areas. Data regarding these areas is readily available

from the claims processor. Additionally, there are times when the contractor authorizes care to health care providers not accepting CHAMPUS payment. The Government can set some objective incentive measures on the claims portion of the contract and some subjective measures on the education and support portion. With a sound award or incentive fee plan, the Government should be able to incentivize the contractor effectively.

While this appears to be a simple issue not needing incentives, a great deal could be gained from a smooth flow of money. Under the current contracts, claims issues seem to be one of the most significant problem areas for providers and for beneficiaries. This is probably an easy fix.

5. Program Administration.

a. Defining The Services And the Critical Tasks

Program administration represents the business and management function the DoD is hiring the MCS contractor to perform. This comprises developing and maintaining the relationship between the contractor, lead agents and military hospitals; participating on integrated product teams working on contract changes; the process of submitting new and required business proposals and plans; operating its offices, providing health care in concert with military resources and complying with a host of administrative requirements set out in the TRICARE Manual.²⁸¹ These tasks are the behind-the-scenes glue that allows the contract to run as a single system complementing the military direct care system. As such, they can be incentivized as an overall package, or individually, as warranted.

²⁸¹ 32 C.F.R. § 199 (1998).

MCS contractors are in a difficult position. They are required to develop, maintain and manage a civilian managed health care network. This network must work with and complement the existing military health system. Compounding this task, the MCS contractor must tackle integrating the two systems. Integration requires significant contractor management involvement coordinating care efforts between the systems, gathering information and data, reviewing military hospital actions and processes, and reporting the outcomes. Neither the military nor civilian health care providers appreciate this oversight and involvement in their business, but the MCS contractor must make it work to meld the system into a cohesive unit.

Since the TRICARE contracts' purpose is to create a large symbiotic health care system, the working relationships and interactions are crucial. When the civilian providers and military hospitals do not share resources and information, the relationship shortcomings increase the contract administrative burdens. Health care costs also rise because the most cost effective resources remain underutilized. This is a cost the Government ultimately bears. The contract must foster collegial working relationships and relatively simple tasks like sharing patient records. The Government and beneficiaries pay money and spend extra time to obtain repeat care when medical records are not provided back to the MTF or to the civilian specialists. Military and network providers working together develops trust while improving resource allocation and utilization. MCS contractor are the intermediaries required to develop system integration between the military and civilian systems. MCS contractors must also build cooperative management and oversight relationships with the Government.

Encouraging closer working relations between the contractor and Government is important to the system. The Government can foster contractor participation in contract management, integrated product teams, business proposal and plan development and daily operations. Both the Government and contractor benefit when dedicating resources to each other's contract performance processes and endeavors. Overintegration presents problems because the parties lose sight of who they represent.

However, it is important for the contractor to work closely with the Government. Procurements are traditionally managed solely by the Government without much input from the contractors. Requirement and policy changes are usually issued to the contractor without any input or preparation. The work is usually dictated to the contractor with no opportunity to suggest better or more cost effective methods. TRICARE will probably be subject to a continuing host of policy and work changes implemented by DoD(HA) direction. MCS contractor involvement in the planning and implementation process allows for a crucial opportunity to ensure the proposed work makes sense and is realistic. In this way, the Government has an avenue to obtain important input regarding methods and pathways to accomplish work in the most effective.

But the best reason to include managed care contractor personnel input is that these people practice commercially and have a world of real life experience. DoD personnel cannot bring that experience to the process. Contractor involvement at this level provides a great sanity check effect, strategy tool and information gathering forum. The Government has nothing to lose by combining forces with the contractor, but a better product and service.

The MCS contractors also must collect information and provide limited guidance to military hospital functions. The contractor does not have the authority to enforce changes. For instance, the MCS contractor will collect data and compare the DoD hospitals to the civilian network and hospitals. This practice will put DoD hospitals under scrutiny and cause their performance to fall in line with civilian medical care practices through peer pressure and competition. If not managed carefully, this competition could prevent establishing sound working relations with the network. These comparisons should help unify the system.

b. Considerations and Structures

TRICARE requires the prime contractor to be the system integrator. As the integrator, much of the MCS contractor's work focuses on management. The contract attempts to require the contractor to establish working relations with various entities in the DoD. Managed care support contractors must integrate their staffs with the DoD to ensure the parties work together in partnership. No metric can objectively measure the success of integration.

A close working relationship permits faster issue resolution and allows the parties to focus on contract performance. The Government can also tell when the relationship is not working well for the parties. Attending each other's meetings, creating joint issue resolution teams, sharing operational information, having open communications lines, and helping resolve common issues indicate the Government and contractor are working together. Shared events like this demonstrate a good program management relationship and need reinforcement. The Government and the contractor can describe the relationship for subjective evaluation purposes. If the Government can structure an incentive that makes it

profitable and cost effective for the contractor to work with the Government, it would ultimately be worth the expense. Incentivizing the contractor to work as an integrator, manager, and “owner” of the process is not a neatly measurable effort, but can be seen subjectively through efforts the MCS contractor undertakes to participate and good working relations with all the parties and the relationships it develops with the DoD.

6. Information Management/Information Technology.

a. Defining The Services And the Critical Tasks

Computer information systems are crucial to any managed care organization.²⁸² Statistics define the organization’s existence through trends, utilization, successes and failures. The numbers help track costs and performance. Increasingly, information systems are a communication backbone for all health care system participants whether they be beneficiaries, the contractor and its personnel, or the Government. First, a robust contractor computer information system is a necessity to the Government and benefits the DoD only when the data is valid and has integrity. All data must be accessible and in a format the Government can readily use. Second, the contractor information system must communicate with DoD systems and not unduly restrict access. This is a tall order considering that the DoD works off of several platforms that do not necessarily communicate. Requiring the contractor to join information systems the Government has not or cannot, may be costly, but is necessary. Third, these systems need to convey information between the parties. The value of a computer information system is clear and the value of a system that fully interacts with the Government’s is immeasurable.

Maintaining data to track all the different health care system elements is the main purpose for the system. Once the data is harvested, the contractor and the Government develop reports regarding all aspects of past and future performance. The MCS contractor must collect and maintain beneficiary specific demographic data network information on capacity and usage, procedures, costs, referrals and authorizations for specialty care, enrollment and customer satisfaction. Additionally, the information systems collect and store data on utilization management, disease management and clinical encounters occurring with beneficiaries. The data is varied, coming from all parts of the contractor's and Government's operations.

Data regarding these managed health care system functions is important and useful only when it has integrity, validity, is meaningful, has a decent sample size and is collected over an extended time period.²⁸³ The information needs to be organized and readily available for analysis and reports. MCS contractors should focus data collection efforts on the overall plan, health centers, and individual providers.²⁸⁴ The data must be further collected according to service lines and beneficiary plan.²⁸⁵ Hospital and outpatient utilization reports are important since they are used to monitor daily plan utilization, track patient and to identify patterns for overall management.²⁸⁶ Profiling individual provider's costs, referrals,

²⁸² Peter R. Kongstvedt, *Data and Reports in Medical Management*, in ESSENTIALS, *supra* note 54 at 173-181.

²⁸³ *See id.*

²⁸⁴ *See id.*

²⁸⁵ *See id.*

²⁸⁶ *See id.*

care episodes, claims and credentialing will help the managed care plan compare the provider against established norms, review provider actions and look at overall “health care resource consumption and outcome.”²⁸⁷ The data and reports can be used to provide feedback from the plan managers to the providers and hospitals.²⁸⁸ It shows the physicians and hospitals their performance and allows them to alter behavior to improve standing, market share and meet peer pressure expectations.²⁸⁹ While data is absolutely crucial, communication is every bit as important.

Managed health care computer information systems are mostly designed as information repositories. With the advent of the internet and electronic mail, information systems represent a viable communications backbone particularly for very large health plans and networks. Network providers can use the system for communication, feedback, referrals, and prescriptions. The health plan can create the ability to electronically file claims, hold training and education over the internet, list specialists for referrals and make rules and policies available. Rather than hiring additional personnel to handle issues relating to these areas and generate reports, the providers can use the internet as an initial resource. The MCS contractors also have the opportunity to speed up the claims payment process by conducting it on line. While speeding up payment, the contractor can also foster a responsive two way feedback path between it and its providers.

Data gathering, report production and communication represent compelling reasons for a capable MCS contractor information system. These functions become more important as the

²⁸⁷ Peter R. Kongstvedt, *Data and Reports in Medical Management*, in ESSENTIALS, *supra* note 54 at 178.

²⁸⁸ *See id.* at 180.

health plan's size grows. The capability, accuracy and responsiveness of the information and the system become crucial. The better quality data, the better access and the more communications access offered by the plan, the more the DoD will realize financial and medical success. Incentivizing any higher data quality, better and increased access and robust communications will only benefit the overall contract operation and TRICARE's success.

b. Considerations and Structures

The Government can clearly define data gathering, communication, and information access goals. The Government could define the data, the communication and information access metrics. The Government may not wish to do so in this case. Simply requiring the contractor to gather the information and data, make it accessible and ensure that all the systems can communicate is to the DoD's benefit. When the DoD is overly specific, it sometimes prevents communication creates overly restrictive interpretations.

A hybrid is probably most appropriate. Awarding objective incentives based on data integrity, minimum access and communications goals would incentivize the contractor to perform to baseline levels. An overall subjective incentive would allow the Government to reward excellence and innovation. The Government may find it appropriate to create a negative incentive on this contract element for errors, mistakes, or system failures. The overall subjective incentive also permits the DoD to retain leverage ensuring the contractor

²⁸⁹ See *id.*

will use information systems for communications purposes that complement the Government's needs.²⁹⁰

VI. Conclusion -

A. *Can It Work?*

Absolutely! The managed health care support services contracts are large, complex, and expensive. The work is ideally suited to a combination of incentive and award fees. Each TRICARE contract started with difficulty. After a time, the services improved and the beneficiaries were satisfied. However, the TRICARE contracts did not save the money projected and costs continued to rise. The Government modified the statements of work to correct for inefficiencies and data errors. TRICARE is clearly a "work-in-progress." These contracts are large enough to place a substantial amount of profit at risk in an incentive program. If the DoD modifies these contracts as appropriate to account for changed conditions, the incentives on the six basic task areas would provide significant economic control over the contractor's priorities and the quality of work.

Performance-based service contracts with incentive and award fees can work. The performance-based service contract statement of work can make the acquisition process easier by allowing the contractor to determine how it will complete the work. While the incentive structure requires some additional cost and oversight, the additional cost is worthwhile. The possibility of receiving superb service accomplishes cost control through

²⁹⁰ See DoD HSRIV Historical Records, *supra* note 17. The managed care support contractors treat the information collected on DoD military and civilian beneficiaries as proprietary. *See id.* Even though it is data the Government owns and collection it bought, the contractors do not provide the data in anything other than paper. *See id.* The DoD had to modify the contract to obtain data it could manipulate with a computer. *See id.*

increased enrollment and more robust provider networks. The award fees with some baseline objective incentives provide a contractor with a balanced opportunity to earn the profit at risk. With the right management and focus, they can combine to reward the contractor for excellence while ensuring the DoD and its beneficiaries have the best of the commercial world's managed health care practices.

B. Is the DoD Ready?

The DOE recently applied performance-based service contracting concepts to its massive management and operating contracts. These acquisitions require a change in institutional attitude. They require the Government reallocate manpower, developing integrated performance work statement teams, reasonably sophisticated cost accounting oversight functions and competent contract administration offices. Is the DoD ready to pursue performance-based contracting in managed health care contracts? It could be. The only question will be whether the Government decides it wishes to spare the manpower to award and administer such a contract? TRICARE Managed Health Care contracts cry out for the flexibility of performance-based contracts and work incentives. This approach ensures the contractor will innovate to be eligible for incentives, the Government will benefit from those cutting edge advances, and both the contractor and Government can keep costs as neutral as possible. Give performance-based service contracts and incentives in TRICARE a chance. It will be a smashing success.